The Journal of

MEDICAL EDUCATION

MINUTES

OF THE PROCEEDINGS

Sixty-Second Annual Meeting

FRENCH LICK, INDIANA

October 29-30-31, 1951

ASSOCIATION OF
AMERICAN MEDICAL COLLEGES

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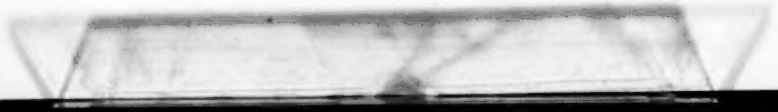

Sixty-Second Annual Meeting
Association of American Medical Colleges
French Lick Springs Hotel, French Lick, Indiana

October 29-30-31, 1951

MONDAY, OCTOBER 29, 1951

(President Arthur C. Bachmeyer presiding)

Opening Address—*Charles Dollard*, president, Carnegie Corporation of New York. (Published in the May 1952 issue of the Journal of MEDICAL EDUCATION Part one, page 161.)

TUESDAY, OCTOBER 30, 1951

(President Arthur C. Bachmeyer presiding)

Symposium on the Conference on Psychiatric Education held at Ithaca, N. Y., June 21-27, 1951. (Published in May 1952 issue of the Journal of MEDICAL EDUCATION Part one, page 166.)

Executive Session and Business Meeting

WEDNESDAY, OCTOBER 31, 1951

(President Arthur C. Bachmeyer presiding)

The final action of the meeting was the induction of Dr. George Packer Berry as President of the Association

Introduction to the Minutes

THE MAY ISSUE of the Journal of MEDICAL EDUCATION covers the high points of 62nd Annual Meeting of the Association. Details of the reports, committee meetings, resolutions and other activities of the French Lick meeting follow in this Journal Supplement.

A wider distribution of the Minutes to all on the mailing list of the Journal was last done 1934, and this issue merely revives a practice of those times.

We hope it will be possible to make this kind of publication an annual procedure, following approximately within two months of the meeting date, for the following reasons:

1. The Minutes help bring the meeting to those who were unable to attend and stimulate their contribution to discussions in Journal pages.

2. A means is provided for acquainting meeting participants with what occurred in sections they were unable to attend.

3. The Proceedings give an overall picture of the range of problems facing medical educators today.

4. The Minutes outline the work of the Association and indicate the constructive efforts being made to solve these problems.

Dean F. Smiley
Secretary

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1950-1951

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Monday, October 29, 1951

Nominating Committee

The Nominating Committee was named by President Arthur Bachmeyer as follows: Walter A. Bloedorn, chairman; Loren Chandler; John D. Van Nuys.

Round Table Discussion Groups

Six round table discussions were held. Subjects, chairmen and discussion groups were:

1. *Regional Hospital Plans and Continuation Education of Physicians*—Rudolph H. Kampmeier, chairman; Edward H. Hashinger; Kinloch Nelson; Harry Towsley; Samuel Proger.

2. *The Threat of Large-Scale Research Programs to the Quality of Medical Education*—Richard Young, chairman; Maxwell M. Wintrobe; James Faulkner.

3. *Medical Teaching on the Ambulant Patient*—David Barr, chairman; Stanley Dorst; Lester Evans; Jacob Horowitz.

4. *Group Practice in Support of Medical Education*—Albert C. Furstenberg, chairman; Charles L. Brown; Willis M. Fowler; Julian D. Hart; Charles F. Wilkinson.

5. *The Influence of Medical Care Insurance Plans on Teaching Material*—Loren Chandler, chairman; Currier McEwen, Paul Hawley; Lowell Coggeshall; Edward Turner; Francis Hodges.

6. *The Means of Appraisal of the Medical Student's Progress and of the Effectiveness of Teaching*—Robert Moore, chairman; C. N. H. Long; John Stalnaker; Thomas A. C. Rennie; Ralph Tyler.

Open Hearings on Annual Reports of Committees

Open hearings on annual reports of committees were held as follows:

1. *Audiovisual Education* — Chairman, Walter A. Bloedorn; J. S. Butterworth; Clarence de la Chapelle; Joseph Markee; Aura Severinghaus.

2. *Environmental Medicine* — Chairman, Duncan W. Clark; Jean A. Curran; Harry F. Dowling; William W. Frye; David Rutstein; Leo Simmons; Ernest Stebbins.

3. *Financial Aid to Medical Education* —Chairman, George Packer Berry; Arthur C. Bachmeyer; Walter A. Bloedorn; Melvin A. Casberg; Ward Darley; Joseph C. Hinsey; Vernon Lippard.

4. *Foreign Students*—Chairman, Francis Scott Smyth; Maxwell E. Lapham; C. N. H. Long; Harry A. Pierson; Aura E. Severinghaus; Edward L. Turner; Francis A. Young; E. Grey Dimond; Frode Jensen.

5. *Internships and Residencies*—Chairman, John B. Youmans; D. W. E. Baird; W. A. Bloedorn; Warren T. Brown; Coy C. Carpenter; L. R. Chandler; J. A. Curran; Stanley Dorst; Reginald Fitz; Maxwell E. Lapham; H. C. Lueth; John McK. Mitchell; Francis J. Mullin; C. J. Smyth; Wesley Spink; R. Hugh Wood.

6. *Planning for National Emergency*—Chairman, Stockton Kimball; George Packer Berry; John Z. Bowers; Melvin Casberg; Edward L. Turner.

7. *Postdoctoral Education* — Chairman, John Truslow; George N. Aagaard; Kendall Corbin; Aims C. McGuinness; Charles Wilkinson.

8. *Public Information* — Acting Chairman, Loren Chandler; George N. Aagaard; Franklin D. Murphy; Ralph Rohweder; Dean F. Smiley; John D. Van Nuys.

9. *Student Personnel Practices*—Chairman, Carlyle Jacobsen; George Packer Berry; D. Bailey Calvin; John Deitrick; Thomas Hunter; Richard H. Young.

10. *Veterans Administration — Medical School Relationships*—Chairman, R. Hugh Wood; Harold Diehl; Reginald Fitz; B. O. Raulston.

Problems of the Internship Placement Program

At a meeting of all member representatives, called for discussion of "Problems of the Internship Placement Program," the following letter was read:

National Interassociation Committee on Internships

October 25, 1951

To the Dean and Hospital Administrator:

The NICI is anxious to have full student participation, understanding and genuine support of the matching plan for

internship appointment. In order to allow more time for student consideration, the deadline for the receipt of student agreements is being extended to November 15, 1951. This can be done without interfering with the other scheduled dates of the plan. For the benefit of the students and the hospital, his credentials should be sent to the participating hospitals to which he has applied as soon as possible after his student agreement is signed. Many student agreements have already been received.

Students from a number of medical schools met in New York on October 21 to discuss the matching plan. They raised objections, especially that the plan had been adopted without student consultation. There were many misunderstandings about how the plan would work, and resentments at pressures they believed were being imposed on them.

The majority of the students attending the New York meeting, however, favored the fundamental idea of a matching plan. The NICI will give full consideration to proposals from students suggesting feasible modification leading to the improvement of the plan, if the student proposals are presented promptly and with sufficient specificity to permit careful study. Obviously no changes can be made, however, without the approval of both the students and hospitals.

Information about the matching plan has been confusing on the point of confidential statements between student and hospital. Such informal agreements between some students and some hospitals, whether unwise or not, will undoubtedly be made. They will be valid, however, only to the extent that they are supported by the official confidential rating blanks submitted by both hospital and student.

Hospitals should appreciate that students resent what they consider unfair pressures which force early commitments. Frank exploration of mutual interests, however, is within the spirit of the plan, although actual commitments limiting the freedom of each should not be entered into. Since both hospitals and students will have full weight given to their preferences in accordance with the order of matching, prior agreements are not necessary.

Sincerely yours,
F. J. Mullin, Chairman

The following resolution was passed:

"That the delegates of the A.A.M.C. work through the NICI to obtain an order of matching, which, it is believed, will work to the best advantage of and be acceptable to, the students and the hospitals, that the students' suggestions be carefully and fully considered in reaching this decision and that the NICI be assured of the full and active support of the A.A.M.C. in whatever action it judges to be best."

The Borden Award

The nominating address for the Borden Award in the Medical Sciences for 1951 was made by David P. Barr as follows:

Five years ago, in 1946, the Borden Company Foundation suggested for consideration of the council of the Association, establishment of an award to be administered by the Association. This was to consist of $1,000 and a gold medal, to be granted each year in recognition of outstanding research in the medical sciences by a member of the faculty of a medical school which itself is a member of this Association.

The list of previous recipients is a distinguished one: 1947, Vincent du Vigneaud, professor of biochemistry at Cornell; 1948, George N. Papanicolaou, professor of clinical anatomy at Cornell; 1949, Fuller Albright, associate professor of medicine at Harvard; 1950, Gerty T. Cori, professor of pharmacology at Washington University.

Your committee this year was composed of J. S. L. Browne, C. N. H. Long, Harry P. Smith, Edward West and myself. We had the exciting but difficult task of considering the merits of 17 worthy candidates proposed by members of the Association. As chairman of your committee, I have the honor of announcing its selection and nomination; Dr. Edwin Bennett Astwood, research professor of medicine at Tufts Medical School.

Born in Bermuda, he is a product of education in his native island, Canada and the United States. He received the degrees of Bachelor of Science from Washington Missionary School, Doctor of Philosophy from Harvard, and Doctor of Medicine from McGill University. He has been a surgical pathologist at Johns Hopkins Hospital, an associate in obstetrics at Johns Hopkins University, pharmacotherapeutist at Peter Bent Brigham Hospital, endocrinologist at the New England Center Hospital and physician at Boston Dispensary.

In these days of specialization and overspecialization, it is refreshing to encounter a man of broader comprehension who can be at once a biologist, chemist, pharma-

cologist, obstetrician and internist, and even an endocrinologist.

Dr. Astwood has demonstrated surpassing ability to bring together as grist for his mill ingredients from many sources, and to produce from the mixture loaves of unique quality. His investigations have been numerous and diverse. Ever since graduation from medical school, he has been actively engaged in endocrine research and has made basic contributions to a better understanding of the functions of the mammary gland, the pituitary, adrenal, thyroid, ovary, placenta. He has developed a simple method for quantitative determination of pregnanediol in human urine. He has isolated and identified 1-5-vinyl-2-thiooxazolidone, a naturally occurring goitrogenic compound. Recently he has prepared by simple methods an adrenocorticotropic substance over 100 times as active as any previously described.

From 1942 to 1950 his efforts were concentrated on experimental studies relative to the chemical regulation of the rate of formation of thyroxine—an endeavor which led to appreciation of the potential value of thiourea compounds, the successful control of hyperthyroidism in man, and the establishment of a new approach in endocrinological research.

In speaking of this contribution by Dr. Astwood, Sir Charles Harrington recently had occasion to say: "A medical world dazzled by the advent of sulfonamides, penicillin and streptomycin has not accorded full recognition to the brilliance of work which goes far and promises to go further toward complete success in the therapy of hyperthyroidism."

In the opinion of the committee, it would be an honor for this Association to make its award this year to a man who has brought relief to so many and who, at the age of 42 and at the height of his productivity, has an accomplishment greater than most very able men can hope for during a long lifetime.

The committee recommends that the 1951 Borden Medal and prize be awarded to Dr. Edwin Bennett Astwood with the following citation:

"For his numerous contributions to the understanding of the glands of internal secretion;

"For his demonstration that the enzymatic processes related to the formation of thyroxine may be interrupted by the administration of chemical agents and that hyperthyroidism in man can be controlled by nonsurgical means;

"For his masterly adaptation of multiple scientific disciplines to the solution of clinical problems and the benefit of mankind."

Presentation of the Borden Award was made by W. A. Wentworth, director of the Borden Company Foundation, as follows:

"It is indeed a pleasure to be here for the purpose of providing the means by which this Association gives recognition to outstanding research in medical science.

"This is the fifth such award you have made. Provision has been made for five more annual awards of this nature. We look forward with gratification and keen anticipation to the continued constructive cooperation to the end that the satisfactions which come to the men and women in our medical schools from their contributions to the advancement of human health and welfare may be perhaps just a little greater.

"Dr. Astwood, your largest satisfaction, I know, comes from the fact that you and your work have been selected by men whose discernment is founded upon their own work of a similar character and with similar facilities.

"The token of that selection of you by them is the gold medal, the reverse of which reads: 'Award for Outstanding Research in Medical Sciences,' and this small slip of paper the face of which reads: '$1,000.'

"May I, on behalf of the Borden Company Foundation, join with all of those who are present tonight in extending congratulations to you for the contribution which you have made and the opportunity still afforded you to make our lives richer and healthier."

After-Dinner Address

President Herman B. Wells of Indiana University delivered the after-dinner address, pointing out some of the areas in the field of medical education where serious problems exist.

In his address, President Wells urged American medical colleges to accept more foreign students as a contribution to attainment of American foreign policy objectives. Such students, he said, would return to their native countries after training as America's best ambassadors.

President Wells also said that American medical schools should encourage graduates of foreign universities to pursue postdoctoral studies in this country, and that more foreign students should be accepted for the four-year general medical course.

Tuesday, October 30, 1951

Executive Session and Business Meeting

Roll Call

Representatives were present from all member institutions except the following:

Medical College of Alabama, Southwestern Medical School of the University of Texas, Dalhousie University Faculty of Medicine, McGill University Faculty of Medicine, Queen's University Faculty of Medicine, University of Alberta Medical Faculty, University of Manitoba Faculty of Medicine, University of Toronto Faculty of Medicine, University of the Philippines College of Medicine.

Introduction of New Deans

The following new deans were introduced by name or in person:

Dr. James J. Durrett, dean of the Medical College of Alabama; Dr. James Allan Campbell, dean of Albany Medical College; Dr. F. J. Mullin, dean, and Dr. John J. Sheinin, president of Chicago Medical School; Dr. F. G. Gillick, dean of Creighton School of Medicine; Dr. Edward H. Hashinger, acting dean of University of Kansas; Dr. Harold Shryock, dean, and Dr. Walter E. Macpherson, president of College of Medical Evangelists; Dr. M. Pinson Neal, acting dean of University of Missouri; James Pinckney Hart, chancellor and acting dean of Southwestern Medical School; Dr. William R. Willard, dean of State University of New York Medical Center at Syracuse; Dr. John F. Sheehan, dean of Stritch School of Medicine; Dr. John B. Truslow, dean of Medical College of Virginia; Dr. A. L. Richard, dean of University of Ottawa Faculty of Medicine.

Approval of Minutes of 61st Annual Meeting

The minutes of the 61st annual meeting, October 23, 24 and 25, in Lake Placid, N.Y., were approved as published.

Work of National Society for Medical Research

RALPH ROHWEDER: It was five years ago that Dr. Carlson arrived at the Edgewater Gulf in Mississippi to report on the first few months of activity by the National Society for Medical Research. At that time, the problems of the National Society for Medical Research were essentially two: first, research and teaching institutions and their leaders had an inclination to evade, to hide the facts about animal experimentation, to maintain a sort of "iron curtain" between the institutions and the public so far as information on animal experimentation was concerned. Second, medical administrators met the practical problems of animal supply on the basis of short-term expediency, using any kind of method—very often backdoor methods—that would work for the present.

Our problem at that time was to reverse those two policies, to argue as diplomatically and forcefully as we could to bring about a change in policies, which we believed were the basis for a gradual but nevertheless relentless loss of ground to the anti-vivisectionists.

In the years since then, those two problems have been fairly well solved. They are not completely solved. There are some people who believe it is the better part of tact and the better part of public relations to hide some of the facts about animal experimentation.

However, the two big problems that face us now are basically different. In the first place, we are about to enter, I believe, a new kind of a controversy.

J. W. Douglas Robertson, the secretary of the Research Defense Society in Great Britain, spent yesterday in our office discussing their problems and their program in Great Britain and its possible application to our problem and our program in America. Dr. Robertson pointed out that anti-vivisectionists, as such, do not constitute much of a problem in Great Britain. The big problem and challenge in Great Britain comes from a group of people who say: "Of course we believe in animal experimentation, we

believe in medical progress, we believe this work should go on, but we don't believe any animals should be made available for experimental use."

As a result of yesterday's conference I feel confirmed in my suspicion that there is in development a movement in this country paralleling that very subtle but insidious semi-antivivisectionist movement in Britain. I think the name of the American organization will be the Animal Welfare Institute. You have all heard about it, but you probably did not know, that the leaders of the Animal Welfare Institute put up the money to get the medical research bill buried last spring in New York.

The Animal Welfare Institute is patterned upon an organization in Britain known as the Universities Federation for Animal Welfare, a sort of an antivivisection fellow-traveler group.

We are going to have a very difficult problem in the next few years contending with this much more subtle kind of opponent. It is not going to be a black-and white argument any more. Our enemies will pretend to be on our side, but they will do various insidious things to see we don't accomplish the things we want.

The other of our two new problems is very difficult to talk about in a large group because it is a very touchy matter. In the last year, we have had an unusual number of successes. The National Society of Medical Research has had a varying role in the successes around the country. More outstanding victories have taken place this year than in any previous year. New laws have been passed in a number of states and a number of cities, and the prospect of victory is very close in other places.

In the course of helping in those campaigns, successful as most of them were, The National Society for Medical Research has gotten itself in trouble for the first time in its history in two ways. First, we have been caught between local factions. There is another problem, however. The attitude behind not telling the public about what you are doing and the attitude behind solving the animal supply problem surreptitiously now has a new manifestation. When a positive legislative campaign is proposed in a state or a community, some of our allies show little faith in what I call "The PTA approach." The "PTA," or "holy crusade" approach consists of going out and selling ideas more vigorously than anybody else. You try to line up more people than anybody else, and you try to put the cause over entirely through the vitality of your promotion.

Some of our people have the sophisticated notion that the better way to get things done is to use back door, political methods. I can tell you from many observations, however, that such a course is not only dangerous but ineffective in the long run. Like paying off a blackmailer, politician trading gets progressively rougher and tougher. Incidentally, the whole appeal of our cause as a holy crusade—pure white against the blacks and grays of the opposition—would be lost and our strength would be dissipated if we were to stoop to back-room political methods.

One of the very difficult problems of the NSMR is trying to convince our people that we are political realists, that we are out to win and yet we don't believe in the kind of things that many sharp, political operators and many very sophisticated public relations persons on the local level advocate.

Progress Report—Survey of Medical Education

Dr. John Deitrick: The 41st and last medical school included in the survey was visited last May. All of you received a letter from the Survey Committee explaining why the survey would not visit all the medical schools. The staff has occupied itself this summer in organizing the materials which I believe most of you can appreciate we brought back by the pound, and that has been fairly well accomplished so that we can use it for the purpose of writing.

The staff who has worked and worked hard on this material during the summer has been composed of some of your regular members: Dr. Stockton Kimball has given us a great deal of his time, as has Dr. Brown of Vermont, Fred Norwood of the College of Medical Evangelists who helped with the writing, Dr. Berson, whom you all know I believe, and myself.

We have taken the position that one of our first jobs is to write down as precisely as we can what a medical school is and does so that the first chapters which we have attempted to write dealt with the activities of a medical school. Those activities as we see them are education, research and service. Having written out those chapters in rough form with the help of the committee members who

have spent a tremendous amount of time with us, we have then tried to challenge ourselves with what are the costs involved in maintaining the activity of these institutions?

The next chapter which we have written out is: are the sources of income available to the institutions to finance these activities? We then propose to go into how the institutions are administered.

That, as I see it now, is the first big division. When we have completed that and rough drafts on all that material, we will get into what I call education proper. I am not prepared to outline our exact chapters and titles in that area yet.

As you know, we have an advisory council. Men selected to serve on it represented rather broad segments of public interest and opinion in medical education. We have presented four of our first chapters to them. They felt the approach clarified to them what actually went on in a medical school. They approved the method of approach and made helpful suggestions to us because of the breadth of their background. We have cleared the chapters with them and so we feel we have polished them up so far as their writing is concerned and say we have them put away, not finally, but we are prepared to move on.

Now we have your Subcommittee on Pre-Professional Education, which also has been working hard. As the committee deals predominantly with the pre-professional education of the students whom you select to enter medical school, they have visited over 100 colleges of education. They have not completed their work, and are continuing to visit more colleges this year.

They plan definitely to hold a large meeting in April where they will, I believe, bring their material together and present it before a large conference. We ourselves are well aware of our deficiencies, I perhaps more even than you, and we know it is going slowly. We will not meet the deadline of January 1. That is, we will not have the entire report written, galley-proofed and so forth by January 1. That is impossible, but we realize our obligation to you, and we hope that we will have your report on your survey prepared so that you may expect to have it in your hands within the next year. We cannot give a time. We are beginning to talk about publishing and the time involved, but to the best of our ability it certainly will be in your hands next year. We cannot give you a definite date.

I can't tell you how much the staff appreciates what you men and your faculties have done. Unless you had been with us it would be almost impossible to have predicted the lack of difficulty on personal contact. I was frightened when I started this. I thought we would deal with men who would know so much more about this that it would bore them to tears if you went around and bothered them. That was not true, and I would think one of the greatest compliments to medical education that can be made is that over the country, in the 41 schools we visited, the interest and the willingness to help went for 99.44 per cent of your faculties.

Work of the Federation of Licensure Boards

WALTER E. VEST: It is a great pleasure to report for that great old man of American medicine, Dr. Walter Bierring. He gave me no instructions as to what to say and he didn't give me too much notice.

I thought I would tell you a little bit about the workings of the Federation of Licensure Boards, its functions and a few of the problems. The first thing that I have gotten out of it as a member has been the exchange of ideas, relatively lengthy and I won't go into that, I will say that personally I have gotten as much out of that feature of it as anything else.

A second function of the federation is to integrate, and as far as possible with the various state statutes, to make uniform licensure procedures, requirements and practices. That is especially true when you come to reciprocity. A state licensing board is that arm of the state government which is the buffer between good medical service and the populace of the state. It is the only legal body that can, on the part of the state, decide who is to be given franchise to practice medicine and who is to be declined. In other words, it is a dragnet to drag out, or to weed out, or to eliminate undesirables and those who are not deemed educationally equivalent to proper practice.

Another function of that board, as I found it, is to keep the incoming members of the state boards informed and educate them in the problems confronting the licensure of physicians.

As I see it, medical licensure is a definite science in itself. You have to study a lot of things and know a lot of things before you are a satisfactory member of the state board.

When you come down to the discussion

of the problems confronting medical education and medical licensure in the federation for the next meeting which Dr. Donald Anderson has told you will be held in February in Chicago, one of the chief topics for discussion is going to be internships and residencies and the equitable distribution of them, if we can have such a thing as equitable distribution.

I am not so sure you can satisfy all the hospitals on the question of interns and residencies, but one of the things that is going to be discussed is whether it is wise, now that the senior year approaches more nearly the internship than ever before in medical education, to do away with the term intern, and give the men who are now interns the term of junior resident, and then have an intermedial and senior residency as well. That is coming up for discussion at the next meeting.

Another function and another thing that we have to face in the Federation of Licensure Boards is the public relations problem of medical licensure. Every now and then—in Virginia recently—you have a hullabaloo about some man who was not allowed to take the examination. It went through the court and all that, and we feel that better public relations should be maintained between licensing boards and the public generally.

I think there is one other function you gentlemen ought to know about. We who are on the other side of the firing line of medicine know that most of the men who graduate nowadays are not well versed in how to integrate themselves into the community. When he gets ready to practice medicine, it is rare to see a young man who knows what he ought to do to get himself adjusted legally in his community and begin the practice of medicine. It is so much so that when we license a man we give him a little talk on what has to be done to make himself entirely legally situated in his community.

Another problem that we have discussed and which we still have to discuss is, of course, the foreign graduate. One factor of that is the Americans who cannot get into the American schools and go abroad, and that problem is going to be increased in my judgment. What are we going to do with the men when they get back? Several of the states have clauses in their licensing laws that limit licenses to men who are graduates of schools recognized by the American Medical Association and schools in America—the schools represented by the example here today.

Then there is the problem of displaced physicians to be discussed in the Federation of Licensing Boards. It has been discussed in the past, and it still comes in for more discussion.

Finally, the problem that must be met by the Federation of Licensing Boards, the medical profession generally, and certainly you gentlemen, is what we are going to do with the osteopaths. The view on the osteopath varies from state to state, and the osteopath has got to go with the homeopath and be integrated into regular medicine.

Work of the Council on Medical Education and Hospitals

DONALD G. ANDERSON: The program and activities of the Council on Medical Education and Hospitals of the American Medical Association are so familiar to all of you that I shall not attempt to review them. Dr. Bachmeyer spoke yesterday of the value of the liaison committee between the Executive Council of the college Association, and the Council on Medical Education and Hospitals. I would like to state that the council has felt that this committee has been a most important and successful instrument for coordinating the activities of our two groups for the overall benefit of medical education.

The committee meets formally at least three times a year, and informally much more frequently. Every one of these meetings proves to be helpful and important in making it possible for us to deal more effectively with both our major and minor mutual problems.

We look forward eagerly to a continuation in the same trend over the next many years of that committee and the course that has been followed during the past 10 years since it was first established.

There is, perhaps, one phase of our program that has not yet become very widely known and I might comment on it briefly. In the internship and residency number of the *Journal of the American Medical Association*, we reported the appointment of an Advisory Committee on Internships comprised of the following men: Dr. Victor Johnson, chairman; Dr. S. Howard Armstrong; Dr. Granville Bennett; Dr. Ulrich Bryner;

Dr. John Leonard; Dr. John McK. Mitchell; Dr. John Paine; Dr. John Romano; Dr. Anthony J. Rourke; Dr. John B. Youmans; Dr. Robert Willson, and Dr. Vernon Lippard. The purpose of this committee is to study and to find, if possible, the place of the internship in medical education today and as far as it is possible to do so, to look forward, certainly to the next 10 or 20 years, and try to predict what the place of the internship in medical education will be.

The second major function of the committee is to study and make recommendations as to what the internship should consist of and how it should be conducted.

Finally, we hope the committee will investigate any other problems related to the internship that seem important or interesting to them. We had the first meeting of the committee last month, and a preview of the scope and program was made. It is too early to tell you when the committee will have its report and recommendations. I imagine it will be at least a year, and possibly longer.

Since the committee at this first meeting did demonstrate an interest in the perennial problem of the disparity between the number of interns and the number of internships, I believe the council will postpone implementation of the quota plan announced last summer until this committee has completed its study and made whatever recommendations it may decide to make with respect to that problem.

A Comparative Study of Essay and Objective Examinations for Medical Students

JOHN T. COWLES and JOHN P. HUBBARD: The National Board of Medical Examiners, with the aid of a grant from the John and Mary R. Markle Foundation, is developing improved written examinations. In view of the increasingly wide usage of the national board examinations, which are given both during and at the end of medical training, the results of this study comparing objective and essay tests are of interest to all who educate or evaluate medical students.

This comparative study of the existing essay-type written tests of the National Board of Medical Examiners and newer objective-type tests in the same subjects has been carried out in cooperation with the Educational Testing Service. In an earlier paper* there has been discussed the evident advantages of the newer objective test techniques which led to the initiation of this project to determine empirically whether the introduction of objective tests might result in a significant improvement in the national board's examinations. Because of its close relationship to the medical schools, both in the construction and the administration of its examinations, the national board has been keenly aware of its responsibility for producing the best examinations possible.

In cooperating with the National Board of Medical Examiners, the Educational Testing Service has drawn from its extensive technical experience not only in preparing, administering and analyzing test material in specialized fields but also, more importantly, in the design of new question types of proven superiority over the traditional factual or true-false objective tests of the classroom. The national board has maintained full and absolute responsibility for the scope, content and even the wording of the objective examination material as it has been accustomed to do in the past for the essay examination questions. The John and Mary R. Markle Foundation has made a generous grant which has made this and later studies possible, and for which we wish to express our grateful appreciation.

Before coming to a final decision as to the advisability of changing the national board's written examinations from essay to the objective, multiple-choice type, it was deemed best to try out the objective examination in only two subjects, one in a basic science of the first two years of medical school and the other in one of the clinical subjects ordinarily given in the junior or senior year. Accordingly, last spring a part of the regularly scheduled examinations in pharmacology and internal medicine was the objective form and part of the same examinations was of the customary essay type. The essay portion was allotted two hours and the objective portion one and a half hours of the total time provided for each of these two subjects.

The essay questions were prepared in the usual manner by the national board's chief examiners in the subjects concerned:

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* Hubbard, J. P.: Consideration of Newer Techniques for the National Board Examinations. Proc. 47th Ann. Cong. on Med. Edu. and Lic., from *Medical Education in the United States and Canada*. Chicago: Council on Medical Education and Hospitals, 1951. pp. 50-53.

Dr. Currier McEwen in medicine and Dr. Eugene Geiling in pharmacology. For the preparation of the objective questions, the same two chief examiners each appointed from his subject field a committee of outstanding leaders to serve under his chairmanship in this new work. Each of these two committees met first in Princeton with test development staff of the Educational Testing Service to decide upon scope of the new tests and best types of questions; then, in accordance with specific assignments, each committee member drafted a set of objective test items.

In general, the selected item types emphasized, wherever possible, the application of fundamental facts or principles in practical medical situations rather than mere recollection or recognition of isolated facts. Many of these objective questions penetrated deeply into a wide variety of aspects of a single symptom or syndrome. Case histories, for example, were generously used in the internal medicine examination, and interpretive or applicatory questions were based on those cases. In the pharmacology examination, item types included quantitative or qualitative comparisons of conditions and effects, and classification of drugs and their action, as well as questions of essential basic knowledge. All questions were put into multiple-choice form to reduce the chance element and facilitate uniform scoring methods.

As might be expected, the committee members found it exceedingly exacting work to devise sound objective test items as compared with the writing of essay questions in the same field. To insure against ambiguous, irrelevant or otherwise weak items, each committee member studied and criticized the work of the other, and finally the committee met a second time to formulate the final examination. Thus the objective test questions do not represent the opinion of any one person or any particular locality, but rather the composite work of a committee of experts from several schools from different parts of the country.

Approximately 1360 students took the combined medicine examination in April 1951, and about 1900 took the combined pharmacology examination in June 1951. Of the candidates who took the combined examination in medicine, there were 697 from schools which require national board examinations. This number constituted a special study group for which statistical comparisons were planned among the following three measures: (a) the grades on the essay portion of the examination, (b) the scores on the objective portion of the examination, and (c) the standing of the individual students in internal medicine as reported by their respective schools. For the latter rating, the schools were requested merely to indicate which students were in the top 20 per cent and in the bottom 20 per cent of the class in respect to proficiency in internal medicine. The confidential ratings of 636 students were generously provided by their medical schools prior to the national board examinations. The following coefficients of correlation were then obtained on that group:

CORRELATIONS AMONG MEDICINE TESTS AND SCHOOL RATINGS

Variables	Correlation Coefficient of
Essay and objective test	.22
Essay test and school ratings (high, middle, low)	.21
Objective test and school ratings (high, middle, low)	.37

These correlations indicate that there is a significant but low positive relationship between essay test scores and objective test scores, and between essay test scores and the school ratings. The objective test scores, however, correlate significantly better with the ratings than do the essay test scores.* When the middle group is excluded, it is even more apparent that the objective test does a better job of discriminating between high and low ranking students as rated by their schools; with this reduced criterion group of top and bottom fifths only, the essay test correlates .31 with school ratings and the objective test .53 with school ratings.

The superiority of the objective test in discriminating the high and low groups also was seen in the relatively smaller overlap of the objective test score distributions for high and low rated groups than occurred in the distributions of essay grades for those two groups. In short, the objective test scores correspond much more closely with the long-term evaluation of students in internal medicine by their instructors than do the essay test grades.

It was not possible to make a statistical estimate of the reliability of the essay

*Using the Cochran-Hotelling t-test for difference between correlated r's, this difference is significant at the 1 per cent level.

grades; that is, an estimate of the accuracy of measurement or of stability of the individual grades if the same students should take the essay tests again. The objective test, however, did lend itself to such an appraisal. It was found that the objective test, even though it was only half as long in time as the customary full-length essay examinations, had satisfactory reliability, comparing more than favorably with reliability estimates obtained from other essay tests.*

Other characteristics of the objective test scores such as total distribution, range, variance, influence of speed and level of difficulty were quite satisfactory for this initial objective test.** Individual test items now have been subjected to rather complete statistical analysis to determine their difficulty, discrimination and other characteristics. These item analyses will serve as a guide for preparation of any future forms or revisions of an objective test in internal medicine.

A similar analysis of the results of the combined examination in pharmacology was carried out. Of the total number of students who took this examination, 546 were from schools which require the examination. Again this number, after proficiency ratings by their pharmacology instructors, constituted a special study group for which statistical comparisons were made among the same measures as in the case of the medicine examination. The coefficients of correlation based on this special group of 546 are as follows:

CORRELATIONS AMONG PHARMACOLOGY TESTS AND SCHOOL RATINGS

Variables	Coefficient of Correlation
Essay test and objective test	.23
Essay test and school ratings (high, middle, low)	.18
Objective test and school ratings (high, middle, low)	.49

*Estimates of reliability by Kuder-Richardson formula 20 for each of the three, 90-minute comparable forms of the objective medicine test were r=.75, .79, and .81 respectively, based on three different groups of 370 examinees.

**Evidence of the unspeeded nature of the objective test is the fact that over 97 per cent of the examinees completed it; the distribution of per cents of examinees answering each item correctly indicated that the initial forms may have been somewhat too easy for the groups tested. More than half of the examinees earned raw scores of at least 75 out of a possible 100 points. The mean correlation of each objective item with total test score was .37.

Again, as for the medicine test, it was observed that the correlation of objective test scores and school ratings was significantly greater than either of the correlations involving essay test grades.† If the school ratings may be accepted as a suitable criterion, it may then be said that these objective tests in medicine and pharmacology are more valid measures of student proficiency than the essay tests in those subjects.

As in the case of the objective medicine examination, the objective pharmacology examination was put through its statistical paces in order to determine its reliability, difficulty, the influence of speed, range and variance of scores and so on.†† Similarly, each test question was subjected to thorough statistical evaluation to determine difficulty, consistency and other attributes of importance in considering whether it should be retained for future use, revised or discarded. The pharmacology objective test proved to have high reliability, but like the medicine test, was perhaps too easy for the group tested. This can be adjusted in later examinations by appropriate choice of items of higher difficulty. Objective tests easily lend themselves to this process of recurrent revision and improvement.

The next step was to combine equitably the grades from the essay and the objective part of each examination to arrive at a final grade for each student. From the correlations cited above, optimal weights were determined for combining the two portions of the examination into a single composite grade. After applying these weights, the combined scores thus obtained were converted to a grade scale corresponding to the percentage grades customarily used by the national board whereby any grade below 75 per cent is considered a failure, 75 per cent and above is considered passing, and 88 per cent and above denotes honors.

In order to make these conversions consistent with past national board grades, a compilation was made of all grades assigned in medicine during the preceding

† When the correlations were limited to the high and low rated groups only: essay test and school ratings, r = .28; objective test and school ratings, r = .68.

†† Estimated reliability (Kuder-Richardson) was .84, .84 and .86 respectively for the three, 90-minute objective pharmacology tests, each based on 370 examinees. Over 97 per cent of the examinees completed the test. About half of the examinees earned raw scores of at least 125 out of a possible 171 points. The mean correlation of each objective item with total score was .30.

six years. For this period the average number of failures in medicine was 11 per cent and the average number of honor grades was 10 per cent. During the same period the corresponding averages for pharmacology were about 17 per cent failures and 15 per cent honor grades. Therefore, in establishing the critical points of the final scale, the percentages derived from the six-year averages were closely maintained.* At each stage in these decisions as to appropriate weights for the objective and essay tests, and suitable proportions of honor and failing grades, the Examination Committee of the national board has been brought into consultation.

In view of the satisfactory results of these initial studies, the National Board of Medical Examiners has considered it advisable to undertake the conversion of other subjects. Accordingly, three more working committees have been appointed and have met, and work has begun on the preparation of objective examinations in pathology, pediatrics, and public health and preventive medicine. These examinations, which will be ready for administration in April and June 1952, will be completely of the objective type and also will be subjected to thorough and critical analysis.

In conclusion, it may be said that the National Board of Medical Examiners, together with the Educational Testing Service and with the generous help of the Markle Foundation, are well launched in a study of the value of objective, multiple-choice examinations for the testing of medical students during and after their medical school training. Preliminary results from this study indicate certain significant advantages of these newer testing methods. Conspicuous among these advantages, the following two are outstanding: (1) the objective examination, when carefully and diligently prepared, appears to offer more reliable and valid evaluation of the student's knowledge and his ability to apply that knowledge to the situation at hand than can be obtained from the time-honored essay examination; (2) the objective examination lends itself to thorough statistical analysis so that it may be accurately and intensively assessed, leading to recurrent revisions permitting steady improvement of these examinations.

*It may be of interest to note that the appropriate scores on the objective test, in terms of per cent correct answers at which the honor and failings points would have been set if there had been no essay test scores to combine, would have been approximately: pharmacology, 80 per cent correct answers for honor, 65 per cent correct answers for fail; medicine, 82 per cent correct answers for honor, 63 per cent correct answers for fail. These cutoffs would have yielded very close to the six-year proportions of honor and fail grades for each subject.

Recent Advances in Physical Medicine and Rehabilitation in the United States

EARL C. ELKINS: With the establishment of an American Board of Physical Medicine and Rehabilitation in 1947, and with the inauguration of a regular Section on Physical Medicine and Rehabilitation in the American Medical Association in 1950, this new medical discipline has achieved full stature.

As the specialty is now practiced, not only are physical agents employed for the definitive treatment of various diseases, but methods of rehabilitation of convalescent and seriously disabled persons also are utilized. The physiatrist now has made a place for himself as one of the team of medical collaborators in the properly organized teaching hospital and medical school. Physical medicine and rehabilitation has become a major professional service in the Army and Veterans Administration hospitals as well as in many civilian hospitals. It seems logical, therefore, for medical educators to organize adequate programs of teaching for undergraduate medical students, graduate medical students and ancillary personnel such as physical therapists and occupational therapists.

Already at least 45 of the 72 medical schools provide some instruction in the subject. Thirty-eight report that they have departments of physical medicine and rehabilitation and 33 schools state that they have already appointed one or more qualified specialists (physiatrists) to their faculties. Likewise, 20 additional schools, which now do not have fully organized programs of teaching, have expressed an interest in the establishment of such programs. There are 87 approved residencies in physical medicine and rehabilitation available at 43 different hospitals annually.

At present there are 31 approved schools of physical therapy and 24 approved schools of occupational therapy. In addition, 15 medical schools are contemplating the establishment of new schools of physical therapy and 14 schools are considering new schools of occupational therapy. Only 11 medical schools

do not appear to be particularly interested in developing adequate teaching programs in physical medicine and rehabilitation, and it is to be hoped that with further study, these schools will become interested.

Because of the importance of the specialty in time of national emergency, it has been recommended that approximately 50 *additional* hours of the undergraduate curriculum be devoted to the teaching of physical medicine and rehabilitation. Ideally, such teaching should be developed by the organization of a separate department of physical medicine and rehabilitation in the teaching hospital. Furthermore, this department should be directed by a qualified physiatrist who should provide the integrated didactic lectures and clinical instruction necessary. This new specialty has now reached a degree of importance in solving the medical problems now existing in our troubled world which renders it advisable for medical schools to make extraordinary efforts toward establishment of adequate programs of instruction in the subject.

Because there is an urgent need for greater advancement and facilities for teaching, the Advisory Committee on Education of the Council on Physical Medicine and Rehabilitation and the council, with assistance from others at A.M.A. headquarters, are attempting to gather information which will point out the need and which may be of assistance to the medical educator.

A report of some of the findings has been compiled and mimeographed and is obtainable. Further studies are being made to gather material which may be pertinent to the problem of organization of facilities. These will be published as soon as they can be compiled.

Report of the National Interassociation Committee on Internships

F. J. MULLIN, chairman: The present matching plan with the definite order of matching student choice and hospital choice was first presented in the *Journal of the Association of American Medical Colleges* in November of 1950. It previously had been discussed and approved in meetings of the Internships and Residencies Committee of the Association of American Medical Colleges.

A National Interassociation Committee on Internships group, under the sponsorship of the Committee on Internships and Residencies of the Association of American Medical Colleges, met for the first time shortly after this. After considerable exploration, it selected from among alternatives the order of matching which everyone felt would give the greatest benefit to all students in attaining the best internships open to them, while at the same time being fair to the hospitals. It was felt in the committee that the only justification for the plan at all was the increased opportunity offered to all students alike on a national basis to obtain a better internship than generally had been true under the previous systems. The committee felt that no plan could succeed unless it had the full cooperation and continued support of both students and hospitals.

In the issue of April 28, 1951, of the *Journal of the American Medical Association*, and in the May, 1951, volume of *Hospitals*, journal of the American Hospital Association, the plan also was presented and the order of matching given.

At a meeting on May 23, 1951, the previous National Interassociation Committee on Internships, on the basis of an analysis of a trial run last year and after considerations of the dissatisfaction of the older method of notification, decided that the plan was desirable and that it justified the recommendation of its use for the present year.

In view of the mounting unrest among the hospitals using the old cooperative plan, it was felt imperative to offer this plan immediately. On June 8, 1951, a full report of the trial run of the matching plan was sent to all deans and all hospital administrators. Again the same order of matching was given. At that time the deans and hospital administrators were asked for suggestions and comments concerning the report of the proposed plan and the recommended actions. Both groups had been asked for suggestions at the time the trial run was undertaken. It was only a couple of weeks ago that extensive criticisms and suggestions were forthcoming.

Following the June 8 meeting, the American Hospital Association membership and the deans of the medical schools of this country voted overwhelmingly for the adoption of the plan as the official method of internship appointment this year. In the A.A.M.C. group the only three who voted against the plan promised full cooperation if it were adopted by the majority. The plan also was endorsed and supported completely by the Council

on Medical Education and Hospitals.

As a result of the support of these groups, joined later by the Catholic Hospital Association, American Protestant Hospital Association and the federal services concerned with internship, a new National Interassociation Committee on Internships was established late in July 1951. This committee of representatives from all these groups was set up with power to act on procedural matters relating to internship appointment. The committee is responsible to the constituent bodies of the American Hospital Association, Council on Medical Education and Hospitals of the American Medical Association and Association of American Medical Colleges for approval on policy matters.

The committee then set about the task of arranging the plan for this year, first calling upon the hospitals to join. They were asked to give information to the committee for inclusion in the directory to be made available to all the students. This official directory lists the participating hospitals and the internships they have to offer. The hospitals were asked to go into this cooperative venture on the assumption that there would be full student participation.

The committee has not always had smooth sailing in its effort to implement the plan despite the fact that many deans and students have given their full support to this venture and already have agreed to participate without reservation. Some of you may not know that even after the plan had been officially adopted, some hospitals were definitely opposed to the plan and sent telegrams and other communications to many other hospitals urging them not to participate in the plan.

Through the efforts of the officers of the American Hospital Association, particularly Dr. Edwin Crosby, president-elect, and George Bugbee, secretary, the hospitals finally agreed to the plan in a very substantial number, so that at the present time there are only 15 hospitals in the country which have not signed agreements to participate in the plan. The statesmanship of these men in working to implement the previous commitment of their group is an example of the genuine effort that many people have put into this attempt to help the students get full educational value out of their internship year. This is the first time there ever has been an actual signed agreement on the part of the individual hospitals to cooperate with the medical schools and the students in the internship appointment procedure. This is especially significant for the educational opportunities available in the internship year.

The National Interassociation Committee on Internships, in its desire to allow as great an opportunity as possible for the students to study and understand the proposals put to them, has extended the deadline for student participation to the last reasonable moment. The committee has before it a plan, already approved by the executive group, for student participation on the committee. It was not possible to manage for such student participation in the time available for the initiation of this plan last summer.

The overwhelming majority of approved hospitals have accepted this plan in good faith and on the assumption that there would be full student participation. If we are unable to secure such student participation and cooperation, then it is only fair that we notify the cooperating hospitals immediately and release them from their obligation to be bound to this method of intern placement. It should be clearly understood that the failure of any substantial proportion of the students to participate means the collapse of our cooperative efforts to bring improvement into the method of selection of interns. In fairness to those hospitals and other cooperative groups, including deans and students, who have made every effort to make this cooperative venture work, they must know at once if there is to be any change. We must be sure that those hospitals which are not cooperating or those which are willing to go back on their agreements may not be given undue advantage through our delay in the unregulated scramble for interns and internships which is certain to follow abandonment or serious defection from the present cooperative efforts of the various groups concerned with internships. As a consequence of the decision of this Association last summer to participate officially in the matching plan, we have the responsibility of explaining the plan thoroughly to our students. We are bound to make every effort in securing the degree of student participation necessary to keep faith with the hospitals and students who have already agreed to cooperate in this plan designed to enable all the students of the country to obtain the best internships open to them, according to their expressed preference consistent with hospital evaluation and with fairness to all.

Since the matching plan must, by its very nature, be a closed system, we have asked the hospitals to promise to limit internship appointments to participants matched with them through the plan until after the notification of such selections. The hospitals in the matching plan have agreed to make no appointments or offers of appointment to seniors applying for their first year internships listed in the official directory until after the results of the matching plan are available. Parenthetically, I would like to add that it would be hypocritical of us as deans, therefore, openly to invite the hospitals to violate their agreement by sending credentials and letters of recommendation to participating hospitals for nonparticipating students until after the announcement of the results of the matching. We certainly cannot expect others to be any more honest or to live up to the responsibilities of commitments to any greater degree than we ourselves are willing to do.

Now is the time for wise educational leadership. It is necessary that the students realize the significance of their actions and have confidence in the judgment of their teachers as expressed in the overwhelming vote of the deans last summer to adopt this plan. This decision was reinforced in the unanimous vote of the Association yesterday afternoon instructing our delegates to secure consideration by the National Interassociation Committee on Internships of the desirability and the feasibility of recent proposals by some students to shift the emphasis in favor of the hospital rather than the student in the matching procedures. Such study has already been promised for the committee, and we are now awaiting a detailed statement of the Boston plan which we are assured will be available in a few days. The previous communications about this plan sent out by the Harvard students have not been sufficiently specific to allow for careful study and analysis of its full implications. It may well be possible to incorporate such suggestions for improvements as may be made if they are found feasible after full study.

Dr. Youmans' motion, unanimously accepted by this group yesterday, also contained the proposition that the Association of American Medical Colleges would be prepared to back up whatever action the National Interassociation Committee on Internships should determine as necessary to preserve order and fairness in the method of intern appointment. This means that every one of us has, by this vote as well as by the earlier one, agreed to back completely the matching plan as it now exists or as it may be modified by the committee at its forthcoming meeting. I am certain that the members of the National Interassociation Committee will, with reasonableness and integrity, live up to this responsibility and faith imposed in them. We are all working toward the same end, and the wholehearted cooperation and firm belief in the integrity of all is necessary to achieve this goal.

The National Fund for Medical Education

CHASE MELLEN JR: Here is a short pamphlet entitled "A Solution for the Financial Crisis Confronting the Medical Schools." It contains an up to the minute report on the progress made by the fund besides an appeal to corporations to join with those that have already contributed so generously. Mr. Colt mailed it yesterday to some 400 large and leading companies throughout the nation.

Please slip a copy in your pocket and please be good enough to read it when you have a few spare minutes. To permit me to conform to the precepts on brevity, may I ask that you accept the pamphlet as my report to this meeting.

By so doing, I shall have the time in which to make an additional comment regarding the fund.

On the first page of the little green pamphlet you will find Article I of the By-Laws. The first objective stated therein reads as follows: *The interpretation of the needs of medical education to the American public.* This is vital and is where the Association of American Medical Colleges can help materially. Dr. Deitrick's report is anxiously awaited in this connection.

Most Americans are generous and responsive to causes of national necessity and need. It is essential, however, to let them know the whys and wherefores—also the extent of the need.

We in the fund find that, generally speaking, our people are not aware of the urgent need of medical education for new sources of financial support. They know little of your struggles to maintain high teaching standards and to recruit a sufficient number of qualified men and women to enter the medical teaching ranks. Since these needs are an intimate part of your daily lives, it seems obvious that you are the ones best qualified to tell

the facts of life to Mr. and Mrs. John Q. Public.

Therefore, in conclusion and with a desire to be constructive, I shall make just one suggestion. In following it you can, I believe, materially help the fund trustees in gaining ever widening support for the fund; support that will bring relief to your hard-pressed medical schools. The suggestion is that you make every effort and that you grasp every opportunity to make the needs of the medical schools a matter of common public knowledge. Please don't treat them as a confidence between doctor and patient.

I further suggest that, like Joshua, you raise your trumpet high and blow it loud and clear. By so doing I am confident that all public apathy or corporation resistance to your pressing financial needs will crumble as did the walls of Jericho.

The Student American Medical Association

RUSSELL F. STAUDACHER: Dr. Hinsey, in his introduction, indicated that I keep the wolf from the door by working as the executive secretary for two new medical organizations, the American Medical Education Foundation and S.A.M.A. This morning, however, I shall don the cap of the Student American Medical Association and confine my remarks to a chronicling of the short but progressive history of this organization.

A national student medical organization is not something new; it's only new in the United States. In fact, medical students in this country, by organizing last December, became the last group of American professional students to do so. Prior to this the Student American Pharmaceutical Association had academic societies in practically every school of pharmacy. Student dental societies are quite common in our dental schools, while law students have participated in Junior American Bar Association activities for years.

The Canadian Association of Medical Students and Interns boasts 100 per cent school participation and a membership of 95 per cent of all Canadian medical students. The British Medical Student Association has been organized for many years, and has made significant contributions to the students and the British medical profession. Similar student medical associations also exist in Austria, Denmark, Germany, Italy, Switzerland, Netherlands, Norway, Sweden, France and India.

In view of these facts, it is perhaps a little surprising that the doctors of tomorrow, in this greatest country in the world, have been without a representative national organization until only a few short months ago. However, despite this late start, the Student American Medical Association today gives every promise of becoming one of the more important organizations in the medical field and the sort of group which can—and will—reflect credit upon itself and the profession it will soon represent.

Thanks to the cooperation of the medical profession, the deans of the medical schools and the medical students themselves, this fledgling organization today has 41 academic societies in as many medical schools and more than 8,000 members. The prospects for adding at least a score or more new chapters by the time of the first annual session of the House of Delegates this December 27-28 are very good. Should this become reality, it will go far toward establishing the organization as one of sufficient stature and standing to warrant its being invited to present the views of the students in problems related to medical student welfare and medical education. With the continued good help and cooperation of you, who are their leaders, the students may expect to reach their goal.

Another signal achievement of the first 10 months of S.A.M.A.'s maturation has been the adoption of a set of objectives to guide the group in its forward progress. In their deliberations, the councilors labored long and hard to fashion a forward-looking flexible program. These objectives were decided upon after many conferences. Many of the objectives are such that they can come to immediate fruition; others are long-range and will take years to accomplish. The members of S.A.M.A. humbly commend their program to you for your appreciation and studied comments.

The third milestone in organizational success of the Student American Medical Association is the forthcoming *Journal of the Student American Medical Association*. In January 1952, all of the nation's 26,000 medical students—not just S.A.M.A. members—will receive their first issue of a new 72-page monthly publication designed primarily for the medical student and intern.

In this journal will be found all those

features and writings which tend to make a medical student fully cognizant of the responsibilities which lie ahead in the practice of medicine.

The editorial division in this new publication equally divides the contents between the scientific papers of student, intern and physician, and the writings of authorities in the fields of the practical and business side of medicine.

By decision of the council, politics and controversy will find no room in the journal. In its stead, the editors plan to give the student of medicine exactly what he wants, whether it is sharing the experiences of medicine as a science or as a livelihood. The new journal will belong to its readers 100 per cent.

In conclusion, I should like to make an appeal for your cooperation in the establishment and support of a constituent society in each of the recognized medical schools in the country.

We have experienced labor pains and, following them, the pains which accompany growing up, but I am confident that with your cooperation and the good help of your offices, the Student American Medical Association can make a significant contribution to medical students, medical education, the medical profession and the general public in the years which lie ahead.

Report of the Chairman of the Executive Council

JOSEPH C. HINSEY: *Actions taken at Executive Council meeting held October 24, 1950, in Lake Placid, N.Y.:*

A new Committee on the Journal of MEDICAL EDUCATION was named consisting of Lowell T. Coggeshall, chairman; James Faulkner; Robert A. Moore.

The name of the Committee on Preparedness for War was changed to the Planning Committee for National Emergency. Its membership was named as follows: Stockton Kimball, chairman; George Packer Berry; John Z. Bowers; Melvin A. Casberg; Edward L. Turner.

The name of the Committee on Social and Environmental Medicine was changed to the Committee on Environmental Medicine. Its membership was named as follows: Duncan W. Clark, chairman; Jean A. Curran; Harry F. Dowling; William W. Frye; David Rutstein; Leo Simmons; Ernest Stebbins.

The name of the Committee on Students from Abroad was changed to Committee on Foreign Students. Its membership was named as follows: Francis Scott Smyth, chairman; Maxwell E. Lapham; C. N. H. Long; Harry A. Pierson; Aura E. Severinghaus; Edward L. Turner; Francis A. Young.

An ad hoc committee to explore the possibility of organizing teaching institutes under the direction of the Association was appointed. It consisted of Dr. Arthur C. Bachmeyer, chairman; Dean F. Smiley; John Stalnaker.

Announcement was made of a grant from the John and Mary R. Markle Foundation, made October 18, 1950, under the following terms:

"That, from the funds available for appropriation Ninety Thousand Dollars ($90,000)—or as much thereof as may be necessary—be appropriated to the Association of American Medical Colleges as an emergency grant, payable on or before December 31, 1952." No publicity will be given this announcement until definite projects under it are undertaken.

The following resolution initiated by the round table on "Specific Internship Requirements for Licensure—Yes or No" was submitted to the Committee on Internships and Residencies: "Resolved that the Association of American Medical Colleges is opposed to the principle of restrictive internship requirements as a prerequisite to state licensure, and approves the appointment of a committee to study this problem in cooperation with the Federation of State Medical Boards of the United States of America."

It was voted that John Stalnaker be named *director of studies* for the Association of American Medical Colleges.

Dr. Dean F. Smiley was made *editor* of the Journal of MEDICAL EDUCATION of the Association of American Medical Colleges.

The decision was made that a managing editor be employed to assist in the production of the Journal of MEDICAL EDUCATION, this editor to be picked in consultation with the editorial board. The decision was made to change the name of the Journal to the Journal of MEDICAL EDUCATION.

Actions Taken at Meetings February 9-13, 1951, *Palmer House, Chicago:*

Administrator Carl R. Gray Jr. of the Veterans Administration with Mr. Byrne and Mr. Dinsdale appeared before the Council. Highlights of his statement were:

(a) He sees no reason for the apprehension of the medical college deans regarding the VA medical care program.

(b) Not a single important recommendation made by the Department of Medicine and Surgery has been adversely acted upon by the administrator.

(c) The administrative organization of the VA is under study by a management engineering concern in Chicago (Booz, Allen & Hamilton).

(d) The recommendations of the University of Minnesota Deans Committee have been received by the administrator and have been turned over to Booz, Allen & Hamilton.

(e) Circular #16 was developed in the effort to make sure that the authority of the physicians in the VA hospitals was sufficient to guarantee overall medical care of a high quality.

Dr. Paul Magnuson read correspondence which appeared to make the following points:

(a) Circular #16, though authorized and distributed, never became a part of the manual under which VA hospital administrators operated.

(b) The definition of the duties of regional office managers and VA hospital managers followed Circular #16 in time and really supplanted it.

(c) Previous to October 1949 the chief medical director had nominated the VA hospital managers. In October 1949 this was made a committee function. In October 1950 the Appointing Committee was named and Dr. Magnuson was not included, though his first assistant was.

(d) Administrator Gray had promised Dr. Magnuson that he would set up a bureau type of organization, the four bureaus to be:

(1) Insurance, (2) Claims, (3) Veterans Rehabilitation and Education, (4) Medical. This he has never done, though the solicitor general assured Dr. Magnuson that the administrator had authority to do so.

(e) The administrator, when asked by Dr. Middleton, "Who is the surgeon general of the VA?", replied, "Under the law, I am."

(f) Dr. Magnuson feels that the chief medical director should stand between all VA hospitals and the administrator. At present he does not.

At the conclusion of these hearings the Executive Council directed Dr. Hugh Wood, chairman of the Committee on Veterans Administration-Medical School Relationships, to prepare a statement. This was revised several times and adopted by the Council. It was prepared for presentation to the Senate investigating committee on the VA headed by Senator Humphrey. (Copy of this has already been sent you.)

The following new committees were appointed:

(a) Liaison Committee with Blue Shield Medical Care Plans, D. F. Smiley, chairman; Lowell T. Coggeshall; Richard Young.

(b) Committee on Post-Doctoral Education, John Truslow, chairman; George N. Aagaard; Kendall Corbin; Aims C. McGuinness; Charles Wilkerson.

The Council went on record as strongly recommending for the present against issuing medical college acceptances, even provisional ones, more than one year previous to matriculation. (Copy of this has already been sent you.)

The Council went on record as recommending to the member colleges an 11-month year for the duration of the emergency but avoidance of the accelerated three-year program if possible. (Copy of this has already been sent you.)

The secretary was instructed to write Dr. Harold Diehl as a member of the Health Resources Advisory Committee of the National Resources Board stating that the Council had gone on record as favoring the setting up of some plan by which selected students would be permitted to drop out of their regular medical course for one year to act as teaching fellows.

On Tuesday evening, February 13, the Executive Council met with the Executive Committee of the Board of Trustees and the Council on Medical Education and Hospitals of the American Medical Association. The whole matter of financial support of medical education was discussed. No definite conclusions, however, were reached.

Actions Taken at Meeting March 18, 1951, Palmer House, Chicago:

The secretary was instructed (a) to draw up appropriate resolutions on the death of Dr. Fred Zapffe and to publish them in the Journal of MEDICAL EDUCATION; (b) to devote a portion of the May issue of the Journal of MEDICAL EDUCATION to setting forth Dr. Zapffe's contributions to the Association and to medical education.

Dr. Hinsey reported on the hearing before the Senate committee investigating the Veterans Administration. In his opinion it was a very satisfactory hearing in that adequate opportunity was given to get all important past difficulties and suggested plans for improvement into the

Senate record. It is Dr. Hinsey's understanding that plans are being drawn for the reorganization of the Veterans Administration which will guarantee that all matters concerning the 147 Veterans Administration hospitals will channel up to the administrator through the chief medical director. (A report of this hearing has already been sent to all member institutions.)

The Council approved in principle a statement being prepared and distributed to the medical colleges by the Joint Committee on Medical Education in Time of National Emergency. This statement includes the following: "The Joint Committee does not recommend that the medical schools at this time adopt an accelerated program."

The secretary was instructed to write a letter to Dr. Daniel Blain, medical director of the American Psychiatric Association, placing our Association on record as endorsing and offering to cooperate in a conference on graduate education in psychiatry projected for June 1952, one year following the conference to be held at Ithaca, N. Y., June 1951, on undergraduate education in psychiatry.

Actions Taken at Meetings May 31 & June 1, 1951, 185 North Wabash Avenue, Chicago:

It was voted that the Association reestablish its membership in the American Council on Education.

A working committee was appointed to prepare a succinct statement of the general objectives of undergraduate medical education, this statement to be revised by the Executive Council before being distributed.

The Council voted to recommend to the Association that the University of Ottawa Faculty of Medicine be voted into affiliate membership in the Association with the stipulation that the school be resurveyed in two years and that its status be reconsidered at that time.

Dr. Thomas Hale was named representative of the Association on the Subcommittee on Education of the American Medical Association's Committee on Medico-Legal Problems.

The Medical Film Institute was requested to begin the preparation and distribution of reference cards for recent medical teaching films, these cards to be comparable to the Library of Congress reference cards for books.

The Council expressed the opinion that each medical school will be well advised to be giving serious thought (a) as to how it can best contribute to the emergency medical care in case of bombing disaster, (b) as to how it would continue its teaching program if its plant were made inoperable as the result of bombing.

The May 23 recommendations of the Interassociation Committee on Internships were approved. This involves a permanent 12-man National Interassociation Committee on Internships operating a machine-matching plan financed by a charge of $2.50 to each student and $2.50 to each hospital for each internship filled through the plan. The individual medical schools are to be polled.

Tentative budgets for the year beginning September 1, 1951, were approved as follows:

The Secretary's office	$66,425
The Journal of Medical Education	35,000
The Committee on Student Personnel Practices	105,000

Action on the Medical Film Institute budget was deferred.

The Council was notified that the Association's representative to the Pan-American Congress on Medical Education in Lima, Peru, in May was Dr. Maxwell Lapham.

Approval was voted for co-sponsorship with the Conference of Professors of Preventive Medicine of a conference on the teaching of preventive medicine to be held within the next two years. Dr. Ward Darley was named co-director.

Summary of Actions Taken at Executive Council Meeting, October 26-27, 1951:

1. The matter of the expiring lease on the Association headquarters space at 185 N. Wabash Avenue, Chicago, was discussed. Decision was made to find new space somewhere in the Chicago area. A committee consisting of Dr. Smiley and Mr. Stalnaker was appointed to bring in recommendations to the Executive Council at its meeting February 7-8, 1952, for the procurement of new space.

2. A schedule of visitations to nine medical schools in cooperation with representatives of the Council on Medical Education and Hospitals was approved.

3. After considering the report of a visitation made October 1-5, 1951, the Council unanimously recommended that at the business session of the 62nd Annual Meeting, the Association vote the University of North Dakota School of Medicine (two-year school of the basic medical sciences) into full membership in the Association.

4. The recommendation was made that the Association's 63rd Annual Meeting be held November 10, 11, 12, 1952, at the Broadmoor Hotel in Colorado Springs. A Long Conference of Professors of Preventive Medicine, of which Dr. Ward Darley will be co-chairman, will take place at the same hotel the week preceding, November 2-8, 1952.

5. The report of Horvath & Horvath's audit of the Association accounts September 1, 1950, through August 31, 1951, was approved.

6. Reports of representatives to important conferences were received and acknowledged as follows: (a) Dr. A. C. Furstenberg, 4th Annual Conference on Aging; (b) Dr. Leland Parr, 9th Meeting of the U.S. National Commission for UNESCO; (c) Dr. Maxwell Lapham, Pan-American Congress on Medical Education.

7. Special consideration as given to the report re the assistance being rendered to foreign students by the Association and its Committee on Foreign Students.

8. Reports of representatives who had served as consultants in the consideration of plans for the development of new medical colleges in Florida and New Jersey were discussed.

9. Approval was given to the recommendation of the Committee on Audio-Visual Education that the name of the Medical Film Institute be changed to Medical Audio-Visual Institute effective February 1, 1952.

10. The Council went on record as approving in principle the U.S. Army's projected plan for establishing military scholarships in the various medical colleges.

As chairman of our Council, I have been deeply grateful for the way that the members of our Association have carried out the responsibilities of these various committees, and I want to express the Council's deep appreciation for the cooperation and the support that we have had.

It wouldn't have been possible to have gotten some of these things through, or all of them as a matter of fact, without the teamwork of our member institutions and their staffs. We are deeply grateful, Mr. President.

Vote of Appreciation

A vote of appreciation of the Association to Dr. Hinsey and the Executive Council for the accomplishments of 1950-51 was unanimously passed.

Action Taken upon the Recommendation of the Executive Council

1. The University of Ottawa Faculty of Medicine was unanimously voted into affiliate membership in the Association with the stipulation that the school be resurveyed in two years and that its status be reconsidered at that time.

2. The University of North Dakota School of Medicine was unanimously voted into full membership in the Association as a two-year school of the basic medical sciences.

3. The Association voted to hold its 63nd Annual Meeting at the Broadmoor Hotel, Colorado Springs, Colo., November 10-11-12, 1952.

Report of the Secretary

DEAN F. SMILEY: This is the first year since 1903 that this Association has met without hearing a report from Dr. Fred Zapffe. He served the Association long and faithfully and as I become better acquainted with the work which the home office is called upon to do, I become more and more amazed at the multiple responsibilities he carried alone, or at most with the aid of two secretaries. You gave him full cooperation throughout his long term of office and pleased him no end when you put the stamp of approval upon his efforts and provided for the future stability of the Association by voting the $500 annual dues. We all owe Fred a deep debt of gratitude, but I am perfectly sure that he died feeling well satisfied that his 50 years of service to the Association had been well invested.

The past year has been a busy one at the home office. The increased financial support provided by membership dues and foundation grants has made possible increased activities. Three new *committees* were appointed and began work. These are: the Liaison Committee with Blue Shield Medical Care Plans, the Committee on Post-Doctoral Education and the Committee on Veterans Administration-Medical School Relationships. Nine of our 14 committees have held one or more meetings with funds now available to make such meetings possible. Half time secretarial help has been provided two of our committees, the Committee on Internships and Residencies and the Committee on Foreign Students.

The *statistical studies* of the Association have been placed on a much more accurate basis and have been extended into

several new areas as Mr. Stalnaker, our director of studies, will report to you. He needs your continuing cooperation in performing this important function.

The *Journal*, with its new name and staff of three, has made many advancements and is hoping to expand to a monthly publication on January 1. Its managing editor, William Swanberg, will give you more details in his report. We hope you will keep the Journal in mind, and we solicit your articles, editorials, news items and letters to the editor.

Medical school visits and inspections this past year included the medical schools of North Carolina University, Howard University, Boston University, the University of Puerto Rico, the University of Ottawa, Creighton University, University of Iowa and the University of North Dakota. Visits are planned for nine schools this coming year.

Several steps forward were made during the year in the field of *public information*. Wide distribution was given our committee's manual, "Public Understanding and Support of Medical Education," and it received very favorable comment. Four thousand copies of our booklet, "Admission Requirements of American Medical Colleges," were distributed, most of them upon request. A roster of public information officers in the medical colleges of the country was prepared and distributed. The second meeting of public relations officers connected with medical schools was held in Miami Beach in June in conjunction with the 35th annual meeting of the American College Public Relations Association. Their meeting next year is to be in Cleveland, and a committee is laying plans for a more extensive seminar on medical school public relations problems. It is hoped the plans will be completed early in the year, and all medical colleges are urged to send a representative to the June meeting.

Requests for assistance from *foreign students* in finding appointments for advanced study in this country have increased this past year. The functions of our office in 43 such cases consisted in (a) providing a copy of our booklet, "Fellowships, Funds and Prizes Available for Graduate Medical Work in the United States and Canada"; (b) forwarding copy of the letters to the Council on Medical Education and Hospitals of the American Medical Association with the request that a list of internships and residencies be sent the student; (c) instructing the student to submit a transcript of his records to Dr. Francis Scott Smyth, chairman of our Committee on Foreign Students, in order that Dr. Smyth may act as his source of reference in this country.

The flood of *questionnaires* directed to medical college deans has apparently continued unabated. Of the 31 submitted to the home office this past year, 13 were approved and 18 disapproved.

Our home office staff has increased to 19 and with the termination of our present lease April 30th, 1952, we will have to find larger quarters. We have moved as rapidly as we could in improving and extending the services rendered. We have as yet been able to do nothing beyond a little exploratory thinking in the promising field of *medical teaching institutes*. A considerable amount of effort has gone into the development of the *Internship Matching Plan* and *Faculty Roster*, as well as the reorganization of the Journal. Important studies in at least two new fields are under consideration by our director of studies. If there are additional services, studies or activities that are urgently needed, we would welcome your suggestions.

Report of the Managing Editor

WILLIAM H. SWANBERG: Volume 26 carried 528 text pages and 123 advertisements. Eighty-five authors contributed 50 original articles. There were 18 pages of editorials, 32 of general news, and 86 pages of college news. Books reviewed totalled 167. I think you will all agree that this is a tremendous bargain for a $5 subscription price! There are some who say, of course, that my judgment in this matter is not as objective as it might be. I maintain that, among other things, Dr. Bachmeyer said substantially the same thing in his address yesterday. He was simply a bit less commercial!

In March of this year, Dr. Dean Smiley succeeded to the editorship and I was privileged to become the Journal's first managing editor.

At the 1950 Annual Meeting, the Journal Committee made several recommendations to the Executive Council. I believe that most of these suggestions have been carried out. The change in the title was the first and most important step toward improvement. Through the name Journal of MEDICAL EDUCATION instead of "Journal of the Association of American Medical Colleges," we call attention to our central purpose: the advancement of medical education. In addi-

tion, the title has a much better eye-and interest-appeal.

There have been several changes in the typographical layout of the Journal and an orientation or summary statement has been added at the beginning of each article. We have carried a list of officers, staff and committees of the Association in each of the past four issues. The College and General News sections have been enlarged. The Book News section has carried longer and signed book reviews of selected books.

Three new sections have made their appearance this year. The Personnel Exchange seeks to help fill vacancies where they exist or to find jobs for those seeking them. The Audiovisual section provides news and audiovisual suggestions, lists new film releases, provides short reviews of films of interest to medical educators and gives credit and source information on these films. The section called Our Readers Write was begun in the September issue. It is a letter-to-the-editor section and will be continued if there are enough worthwhile letters.

On the business side, the mailing list for the Journal is approximately 4,500, which is about the same as a year ago. In the advertising department, a contract was signed last January with a professional advertising representative. The agreement requires that they solicit all possible advertisers, with the exception of book publishers. Thus far they have secured no new ads, though they have glowing promises for next year. Since May, we have written four sales letters to some 30 book publishers. These have brought in $850 in new advertising.

The third main division of the work of the managing editor concerns public information. A public information program for medical education means that you think good medical education is important, that people should know this and give it support, and that you have assigned time and personnel to let them know about good medical education and its needs. In this category, the Journal office answers numerous inquiries for information and sends out press releases to the wire services, certain newspapers and periodicals. Our main claim to news has been an advance copy of the Journal, which we enclose with our press releases. We pick out articles most likely to be of interest to a wider audience and write up a simpler version. So far, our record has been good. We have received newspaper or wire service coverage for some article from each Journal since the May issue. In the field of public relations organizations, the managing editor attended the American College Public Relations Association meeting and the Adams County Model Public Relations meeting. The managing editor can by no means do justice to the Journal and to the real and extremely important requirements of the job of a public information officer for the Association.

Ancillary work done by the Journal office includes consultation to the Medical Film Institute on publication problems and, in the past two months, the handling of publication details for their film reviews.

This ends the formal section of my report but I would like to take a few more minutes to discuss the plans we have for the Journal.

The most important recommendation that I can make is that MEDICAL EDUCATION become a *monthly* publication. There are several reasons: (1) the problems of medical education are important enough to deserve monthly discussion in our official Journal; (2) the news value of the contents is almost completely lost by issuing every other month, and (3) there are enough original papers deserving attention to maintain a monthly publication.

A monthly would mean more text pages per year and therefore more space for the original articles section. At the same time, the size of each issue would be reduced slightly. This would mean that the ratio of advertising pages to text pages would be increased. Increased advertising would pay for more than half of the costs of becoming a monthly. If we can increase the number of subscriptions, it will mean more advertising, higher space rates, and eventually, a Journal that pays its own way.

In conjunction with a monthly we would like to develop a real selling campaign for this needed increase in circulation and advertising. It is essential that the main basis for advertising solicitation be that the Journal is paid for by the people who receive it.

In my opinion, our subscription selling problem would be simplified if the number of copies received by the schools were reduced to 25 per school: one copy to the dean, one to the public relations office, two copies to the library, and one copy to the head of each major department. If only one Journal goes to each department head, rather than a selected few in each department, I think we have

a better chance of selling a subscription to the other members of the department.

Let me say at once that it is not an easy matter to sell advertising if our circulation number is cut in half. In other words, this will make our work more difficult at first. Our long-run goal, however, is some 10 to 20,000 individual subscribers who buy the Journal because of their interest in medical education and because the Journal of MEDICAL EDUCATION is an indispensable aid to their becoming better medical educators. It is essential that we accomplish this goal, and we will need all the help that everyone attending this meeting can give us.

Our plans for the editorial sections of the Journal call for a central focus on the continuing improvement of the original articles section. This takes much more time and energy than people realize.

We hope to be able to devote two or three issues each year to a comprehensive treatment of some of the major topics in medical education.

When we find time and/or material, two additional sections might be added. The title for one could be the Teaching Clinic. This would provide, among other things, an opportunity to record for our readers short reports of teaching experiences, successful or unsuccessful, in specific situations. Another section might be either a bibliography, comment, or summary section on articles of concern to medical educators which have appeared in other journals.

The next two years will be the most difficult ones for the Journal. The welcome aid from the Markle Foundation is providing the funds necessary to help us through this period.

I wish that each of you would consider yourself an unofficial member of the Journal staff. When you have comments or suggestions, news or good articles, please send them to us.

We are fortunate in having an excellent Journal Committee. With their help we plan to produce the kind of Journal of MEDICAL EDUCATION that leads and serves the best in medical education.

Report of the Director of Studies

JOHN M. STALNAKER: At the last annual meeting, the new Executive Council appointed a director of studies for the Association. This is his first report.

The Executive Council did not describe the duties for the director of studies; no report of a person in a similar role has been uncovered. The director of studies can but hope that in this report he has not taken unwarranted advantage of this freedom or stepped outside of any unspecified boundaries which the Executive Council or the Association assumed he would recognize.

Actually, no effort has been made to separate the work of the director of studies for the Committee on Student Personnel Practices from that of the same individual acting for the Association. The central office staff of the Association operates as a team under the friendly guidance of Dr. Dean Smiley. When work needs to be done, the available person does it. It has been the good fortune of the director of studies to work closely with the secretary in helping to keep the office running as smoothly as it has during these active times, and to get the necessary work accomplished.

Some tasks, in many cases small ones, have been done by the director of studies for the Executive Council and for the officers of the Association as well as for some of the committees. Meetings have been attended as a representative of the Association, speeches given, papers published, correspondence handled and numerous memoranda prepared.

The report of the Committee on Student Personnel Practices has outlined the operations which have been the responsibility of the director of studies. This present report will project operations toward the future and describe some of the problems which require solution in the years ahead.

The central office of the Association has undergone marked changes during the past few years. Dr. Fred Zapffe developed the Association and, almost single handed, himself did virtually everything in the office. As is inevitable when such an able pioneering and energetic person drops from the scene and new hands take over, a period of change and adjustment follows. In addition, the Association, in large part as a result of the ground work Dr. Zapffe laid, has taken on new responsibilities and activities appropriate to the group in this time of national development.

It seems, therefore, that a study of the activities of the central office and its most appropriate organization, staffing and financing, could wisely be undertaken at this time, and this type of study is recommended.

Such a study, if properly done, should delineate the general areas where the Association can, in the immediate future,

be especially effective. A rough blueprint for the next few years would have many advantages. It can be developed only by a person familiar both with medical education and with the evolution and development of our culture. It is no small task.

While recognizing fully and acknowledging the many and significant contributions to education by organizations of medical practitioners, the A.A.M.C. should appreciate the legal and actual differences which may exist or develop between the activities of organizations of practitioners and of medical educators. Fortunately, the two groups are by no means mutually exclusive. The overlap at any period should not, however, obscure the desirability for the educator to remain independent and to assume active leadership in matters of medical education, a fact stressed by Dr. Tresidder to this Association some years ago and echoed by others. The great values of close cooperation and coordination of the activities of all groups concerned with medical education should be realized.

The A.A.M.C. could well, at this time, give serious study to the school inspections and accrediting to make sure that the process is kept from degenerating into a means of forcing conformity to nonessentials rather than developing as an aid to focusing the attention on areas of importance for the training of future physicians. The Association should be able to contribute to improvements here, and it has a public responsibility to do so.

As medical education is a field in which public interest is growing, and probably will continue to grow in the next few years, the A.A.M.C. should gather for its own information and for public enlightenment as much factual data about certain phases of medical education as possible, and devise means for presenting such information so that the public will understand it. Supplying statistical data can be annoying, but the fundamental data, if not collected by this Association, will be estimated or derived by others. The amount of pleading and repeated requests required of the central staff of A.A.M.C in the case of a few deans suggests that not all deans appreciate the value of making sound information available. The medical schools, it is recognized, have other duties and concerns than supplying statistics, but the deans should appreciate that the information is being collected for the good of medical education.

There are several obvious areas where statistical studies are now being undertaken with the cooperation of the medical schools. The studies of applicants to the medical schools will be expanded so that more information will be available about the number of students making repeated applications and, if possible, some additional information about the applicants. The study of accomplishment in medical school and the drop-out rate should be brought up to date, and efforts are being made to do so. Such information should be available to the undergraduate colleges. It is particularly important at this time to have accurate information on attrition rate in the medical schools. A new study on some aspects of the faculties now teaching in medical schools is, with the aid of Dr. Rusk's committee, well along. A full report on this study will be made at a later date.

More information probably should be obtained on the cost of medical education. A project on developing certain standardized accounting procedures has much to be said for it. Obviously, all medical schools are not the same and details of accounting must differ. However, certain general principles might be developed applicable to all schools. The use of some general standards could result in revealing information of value to all medical schools.

The internship, like the weather, is something that is widely talked about but very little is done about it. This year the matching plan for internship appointment has been adopted after a trial run. The cooperation of the hospitals in this plan has been overwhelming. Dr. E. L. Crosby, president-elect of the American Hospital Association, has been extremely helpful in securing this degree of cooperation. The A.M.A. council also has cooperated fully. However, within the narrow time limits available, the interassociation committee did not succeed in communicating effectively with the students so that they would recognize and appreciate the values of the plan for them, and the deans apparently did not succeed either. As a result, student opposition has developed. The plan, developed for the benefit of the student, cannot succeed without student cooperation. The plan appears to have advantages over previous plans. With student and hospital support it cannot fail.

Your director of studies has been acting as the director of operations for the National Interassociation Committee on Internships, and has devoted a very large

amount of his time to this work and an even larger amount of his nervous energy.

There are many other possible areas where intensive studies might prove especially fruitful at this time, especially areas concerning the curriculum.

The problem of securing adequate personnel to design and develop these major projects is a greater one than securing adequate financial support. While there is now a small staff working on studies in the Association office, there is still a long way to go before the office will be equipped to turn out, with the desired promptness, the work needed.

Your director of studies, with the approval of the chairman of the Executive Council, has done his stint of government service. Fortunately, his work for the government and also for other outside agencies has brought him into contact with extensive research pertinent to his work in the A.A.M.C. He is serving a second year as a member of the Scientific Advisory Board to General Vandenberg, chief of staff of the Air Force, and as a member of the committee on the selection of men going into the foreign service for the Department of State, and as a consultant to the Navy through the Office of Naval Research. He has also been associated with the research committee of the College Entrance Examination Board, attends many meetings of the Educational Testing Service and has done some committee work for the American Psychological Association. He spoke at meetings of the American Psychological, the American Public Health, and the American Medical associations, and the invitational conference on testing problems, and has attended other conferences.

The period of the last two years has been one of adjustment and learning, staffing and getting basic records into shape. The next several years should see the rounding out of more published reports.

Report of the Treasurer

JOHN B. YOUMANS: Your treasurer is pleased to report that the financial affairs of the Association are generally satisfactory.

During the fiscal year there was a material improvement in our financial position. An excess of general income of $10,585.95 compares with a loss of $211.81 for the preceding fiscal year. This amount has been transferred to the General Fund Reserve, which now totals $30,321.72, compared with $19,735.77 the previous year. This strengthening of the General Fund Reserve provides some insurance for an organization such as ours, which is primarily a spending organization, but is only a minimum amount needed to insure any degree of permanency in the activities of the Association.

It must be pointed out that the fiscal operations of the Association are of two distinct kinds: general operations supported by the unrestricted general income of the Association, and special operations supported by special restricted funds for which, in effect, the Association acts as trustee. However, the general unrestricted income itself has consisted partly of grants from outside agencies, made in support of such activities as the publication of the Journal of MEDICAL EDUCATION. During the past fiscal year, $62,500 of budgeted income was derived directly from unrestricted outside grants. Regular internal income of the Association from members' dues and other sources remained at essentially the same level. It is clear that additional regular, unrestricted, income will be necessary to maintain the activities of the Association should other income be reduced and it is in this connection that a General Fund Reserve is necessary.

Budgets for the new (current) fiscal year include $69,000 derived from unrestricted outside grants, $52,500 transferred from the previous year and $143,600 of regular income, for a total of $265,100. All budgets have been approved by the Executive Council. Details of income and budgets are given on the accompanying exhibits (see page 31).

The Comparative Balance Sheet for the fiscal year 1951 shows total assets of $188,013.97 compared with $195,017.30 as of August 31, 1950, a decrease of $7,003.33 which is represented by an expenditure of special, restricted funds. Investments total $89,779.55 compared with $33,000 the previous year, but the increase is the result of the purchase of short-term securities from working capital not currently needed, thus securing interest income for the Association.

An advance of $5,000 was made to the National Interassociation Internship Committee. This will be repaid from the income of that committee.

During the year, minor changes have been made in account titles to conform with good business practices, and monthly balance sheets have been prepared in addition to income and expense state-

ments, for control purposes. John M. Stalnaker has been authorized to sign checks in the absence of Dr. Dean F. Smiley. Details of the finances are contained in the report of the auditors, Horwath and Horwath, for the fiscal year ending August 31, 1951, which will be filed with this report and presented in abbreviated form in the printed minutes. I recommend that all who are interested in the fiscal affairs of the Association read the report and audit.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Chicago, Illinois

Report on Audit for the Fiscal Year Ended August 31, 1951

Horwath and Horwath have examined the balance sheet of the Association of American Medical Colleges as at August 31, 1951, and the statement of income and expense for the fiscal year then ended, and have presented a report thereon, which consists of the exhibits and schedules and is filed in the Association office, It is summarized here:

Balance Sheet

Assets

CURRENT ASSETS		
Cash		
Petty cash		
Chicago	$ 100.00	
New York	200.00	$ 300.00
Travel advances		400.00
Cash in banks		
First National Bank of Chicago		
General	$ 83,141.70	
Operating	11,786.66	
Bank of Montreal	1,864.54	96,792.90
Accounts receivable—employees		58.20
Deposit—United Air Lines		425.00
Prepaid insurance		258.32
TOTAL CURRENT ASSETS		$ 98,234.42
INVESTMENTS		
United States Government Bonds—Series G		
Face value	$ 33,000.00	
United States Treasury Bills—		
Cost	56,779.55	
TOTAL INVESTMENTS		$ 89,779.55
TOTAL ASSETS		$188,013.97

Liabilities and Reserves

CURRENT LIABILITIES		
Federal income tax withheld from employees	$ 1,084.20	
Federal retirement tax	218.98	
		$ 1,303.18
DEFERRED INCOME		
Dues income 1951-1952	$ 23,750.00	
China Medical Board Grant	50,000.00	

		73,750.00
RESERVES FOR RESTRICTED FUNDS		
Medical Film Institute	$ 14,729.66	
Committee on Student Personnel Practices	41,328.07	
Survey on Medical Education	22,748.02	
National Inter-Association Committee on Internships	3,833.32	
TOTAL RESERVES FOR RESTRICTED FUNDS		82,639.07
GENERAL FUND RESERVE		
Balance August 31, 1950	$ 19,735.77	
Excess of income over expenses September 1, 1950 to August 31, 1951	10,585.95	
TOTAL		30,321.72
TOTAL LIABILITIES AND RESERVES		$188,013.97

SUMMARY OF INCOME AND EXPENDITURES FOR THE YEAR ENDING AUGUST 31, 1951

	Restricted Funds Carried Forward from August 31, 1950	New Income 1950-1951	Expenses 1950-1951	Balance August 31, 1951
Secretary's Office	*	$ 66,541.15	$ 53,544.85	$12,996.30
Journal		25,943.43	28,353.78	(2,410.35) deficit
Committee on Student Personnel Practices	$111,803.48	7,500.00	77,975.41	41,328.07
Medical Film Institute	7,621.83	36,955.58	33,384.40	11,193.01
Projects for Medical Film Institute	1,856.22	49,901.88	48,221.45	3,536.65
Internship Study		5,000.00	1,166.68	3,833.32
Survey on Medical Education	30,000.00	35,000.00	42,251.98	22,748.02
TOTAL	$151,281.53	$226,842.04	$284,898.55	$93,225.02

* The deficit of $211.81 of expense over income in 1949-50 was taken from reserves. Other balances are restricted and carried forward.

BUDGET—1951-1952

SECRETARY'S AND TREASURER'S OFFICE*

INCOME	
Dues—79 Members $500	$ 39,500.00
Dues—8 Affil. Members $125	1,000.00
Interest on Investments	825.00
Overhead	15,000.00
Miscellaneous Income	100.00
Special Grants	21,470.00
	$ 77,895.00
EXPENSES	
Salaries and Annuities	$ 20,000.00

Rent and House Expenses	9,000.00
Supplies, Postage, Telephone and Telegraph, Etc.	10,000.00
Furniture and Equipment	1,000.00
Travel	12,000.00
Administrative Expense	500.00
Annual Meeting	3,000.00
Committee on Internships and Residencies	1,800.00
Medical Film Institute	2,000.00
Contingency	4,125.00
Journal Subscriptions for Members	14,470.00
	$ 77,895.00

JOURNAL OF MEDICAL EDUCATION*

INCOME	
Advertising	$ 10,000.00
Subscriptions and Sales	3,000.00
Special Grant	7,530.00
Subscriptions to Members (from dues)	14,470.00
	$ 35,000.00

EXPENSES	
Salaries	$ 11,770.00
Printing and Mailing	16,750.00
Travel	1,000.00
Circulation Promotion	2,880.00
Advertising Promotion	1,600.00
Furniture and Equipment	1,000.00
	$ 35,000.00

* As revised by Executive Council—February 1952.

COMMITTEE ON STUDENT PERSONNEL PRACTICES

INCOME	
Revenue from Testing	$ 75,000.00
Special Grants—Previous Year	16,503.49
Balance from Previous Year	24,824.58
	$116,328.07

EXPENSES	
Salaries and Annuities	$ 40,000.00
Supplies, Postage, Telephone and Telegraph, Etc.	4,000.00
Furniture and Equipment	2,000.00
Travel	4,000.00
Contracted Service and/or Machines	8,000.00
Markle Grants	
a—Interest Measures	13,479.20
b—Records Work	161.18
c—Brosin Project	2,363.11
Special Studies	10,000.00
Faculty Register	5,000.00
Overhead to Association	15,000.00
Contingency	11,824.58
	$116,328.07

MEDICAL AUDIO-VISUAL INSTITUTE

INCOME	
Special Grants	
China Medical Board	$25,000.00
Sloan Foundation	15,000.00
Association of American Medical Colleges	2,000.00
Projects and Earned Income	
Georgia State Dept. of Health (Maternity)	3,000.00
Geo. Washington University (Birth of a Family)	500.00
Dept. of State (SCC-1a-1156)	1,000.00
Office of Naval Research (N9-onr-93501)	462.71
U. S. P. H. 5.—HTS-5020	718.00
Film Distribution	500.00
Transfer from Previous Year	11,193.01
	$59,373.72
EXPENSES	
Salaries	$41,560.00
Rent and House Expenses	2,500.00
Supplies, Postage, Telephone and Telegraph, Etc.	3,500.00
Furniture and Equipment	1,000.00
Travel	3,800.00
Contracted Services and/or Machines	2,500.00
Annual Meeting and Others	1,000.00
Publications, Reprints, Special Mailing	1,000.00
Contingency	2,513.72
	$59,373.72

Accomplishments and Recommendations of Committees

Committee on Audiovisual Aids

WALTER A. BLOEDORN, chairman: The committee's activities of the past year have consisted largely of the furtherance of the program of the Medical Film Institute of the Association of American Medical Colleges. The committee has met three times: November, April and September, and twice with the Advisory Committee, which incorporates the committee, in November and April. Distinct progress has been achieved toward development of the many types of Institute service to medical audiovisual education.

Financial Support: Financial support of the Institute is based on the concept of the financing of universities and the medical schools themselves: that a large proportion of self-support will derive from services rendered, but that the need for complete self-support should not exist lest it be permitted to endanger the integrity of the program. The Commonwealth Fund, the John and Mary R. Markle Foundation and the Alfred P. Sloan Foundation have continued their basic support into this third year of operations. The Association has added its limited support. There have been Institute earnings. Grants and contracts have added to the Institute assets.

Administration and Organization: The organizational goal of the Institute is a firm program well integrated with the overall Association objectives in medical education. There have been important organizational and administrative improvements in the operation of the Institute. Integration with the secretary's office has progressed directly with the expansion and reorganization of that office. The revivification of the Journal of MEDICAL EDUCATION has opened new channels of continuous and predictable publication for Institute information.

Personnel: It is conceived that the work of the Institute can best be accomplished by a small but skilled staff, with the assistance of expert consultants on call for special needs. Dr. David S. Ruhe and Dr. Adolf Nichtenhauser comprised the basic professional staff. Dr. John L. Meyer II completed his training fellowship July 1, 1951, to be succeeded by Dr. Floyd C. Cornelison Jr. as fellow in training. Mr. George C. Stoney, talented documentary film worker, has joined the staff as specialist in production consultation. In film reviewing activities Mrs. Marie L. Coleman, Dr. Marvin Weinberg, Dr. Norman Lenson, Dr. Louis Bergmann, Dr. Louis Girard, Dr. Benjamin Lewis and many other specialist part-time reviewers have been working with the Institute staff. Bernard V. Dryer and Dr. V. F. Bazilauskas have continued as principal special consultants.

Information and Cataloging: The information services of the Institute are being developed to provide a variety of materials covering the most important aspects of audiovisual planning, production and utilization:

1. A motion picture card index service, nonqualitative in substance and modified from cards of the Library of Congress, has been launched under a cooperative arrangement with the Committee on Medical Motion Pictures of the American Medical Association and the Committee on Medical Motion Picture Films of the American College of Surgeons.

2. A second edition of "Medical Teaching Motion Pictures Now in Production" has been issued in revised form; a third edition is soon to be released.

3. Evaluative cataloging has proceeded under the initiating general grant of the Rockefeller Foundation and under a categorical grant from the National Cancer Institute to review films in neoplastic diseases. A paper, "The Critical Cataloging of Medical Films," was published as a supplement to the Journal of MEDICAL EDUCATION, Vol. 26, No. 3. Sixteen "Reviews of Films in Atomic Medicine" have been published by Health Publications Institute for national distribution. Ten "Reviews of Films in Psychiatry, Psychology and Mental Health" have been given limited distribution, along with 11 "Reviews of Medical and Related Films." Nineteen preliminary reviews of films in "Social and Environmental Factors of Medicine," with report, have been given limited circulation. Fifty miscellaneous reviews are in process of publication and distribution. Thirty-nine reviews of films in neoplastic diseases have been completed and published. A categorical eval-

uative study of the films in the cardiovascular diseases was begun September 1 under a grant from the National Heart Institute. Short condensations of reviews have been initiated in the September issue of The Journal of MEDICAL EDUCATION. Medical schools have been supplied expert panels at Rochester, Syracuse, Albany, Boston and New York City.

It must be emphasized that each Institute review is a detailed and serious study of the film in question; a mine of information for producer and serious user alike.

4. New notes concerning audiovisual personnel and events have begun in the Journal.

5. Numerous letters and calls of inquiry have been serviced.

6. A special study was conducted on "Television and Medical Education," and published in The Journal of MEDICAL EDUCATION, July 1951, Vol. 26, No. 4, pp. 245-259.

Consultation and Liaison Services: From its beginning the Institute was expected to be available for all requests for assistance, from the whole field of medical education. As the result, the Institute's staff and consultants have been called upon frequently and intensively for a wide variety of services to many organizations and individuals concerned with professional audiovisual education:

1. Medical schools. The Medical Film Institute worked with the Joint Committee for Medical Education in Time of National Emergency and with that committee's Sub-Committee on Curriculum. The Institute represented the Association in behalf of medical educational interests before the Federal Communication Commission at the March hearings on educational television. General audiovisual-television surveys were conducted at George Washington University and at Western Reserve University. A result of the latter survey was the establishment of an AV-TV laboratory. Assistance was given to Dr. V. F. Bazilauskas in his AV-TV survey of the State University of New York at New York City. Consultation on films in prospect or production was given to Duke University (Dr. Markee and Dr. Brown), the University of Maryland (Dr. Krantz), The George Washington University (Drs. Parks and McLendon, vide infra), and New York Medical College (Dr. Granirer). Services of varied kinds were offered to Jefferson Medical College, Cornell University, Columbia, Temple, Pennsylvania, University of Buffalo, Washington University (Mo.), and the Medical College of Israel.

2. Assistance was given in a variety of ways to the following organizations or groups: Medicine, American Academy of Pediatrics, Association of American Anatomists, Academy of Ophthalmology and Otolaryngology, New York County Medical Society, New York State Medical Society, Massachusetts Medical Society, U. S. Public Health Service in several of its divisions, American Public Health Association, International Scientific Film Association, New York State Department of Health, deans of the Veterinary Medical Schools, American Colleges of Pharmacy, American Association for the Advancement of Science, medical representatives of the governments of Indonesia, Nationalist China, Jugoslavia, the Clay-Adams Company, the Charles Pfizer Company, United World Films, the National Broadcasting Company (Teleprograms, Inc., vide infra), and the United Nations. Many individuals representing varied medical and health interests were given advice and assistance to the limit of present Institute resources.

Curriculum Integrational Services: Assistance in the curriculum integration of audiovisual aids is at the stage of exploration and evaluation of the available audiovisual materials, or initial implementation of existing plans. The fields of activity continue to be primarily preventive medicine and public health, neoplastic diseases, cardiovascular diseases and psychiatry. Opportunity to work with the Western Reserve University project of curriculum reexamination and rebuilding has been afforded by the appointment of Bernard V. Dryer as director of the new AV-TV laboratory, whose studies are geared into the overall program of that school. Perhaps no more effective chance exists to study the possibilities for saturation of the medical curriculum with audiovisual materials, and to create new patterns and concepts of utilization.

Experimental Production: The work of the Institute in the production of new audiovisual materials has been based on three concepts: (1) that actual creative experience is necessary to maintain and strengthen the consultational skills of the Institute staff for use by the medical schools and other medical agencies; (2) that selected production is necessary to validate presently held ideas about visual educational tools in medicine and therefore should be undertaken with the hope of providing models for emulation, and

(3) that scientific personnel who will be most valuable to medical education in the future must have a real and continuing productional experience. The Institute has therefore continued to undertake a few production projects in line with these concepts.

The two-government film on the progress of cancer research: "Challenge: Science Against Cancer," has been re-edited to a 20-minute version, "The Fight — Science Against Cancer," and a 10-minute newsreel version, "Outlaw Within." A teaching filmstrip has been completed. The book, "The Challenge of Cancer," has received wide circulation. Many honors have been given this film package: "Challenge" received first prize in the scientific division of the International Film Festival at Venice and the Associated Screenwriters script award; "The Fight" was runnerup for the short subject Oscar of the Motion Picture Academy; the book received the Westinghouse Sciencewriters award for text and was placed among the 50 best books of the year for its typography.

"The Embryology of Human Behavior," a motion picture made in conjunction with the Office of Naval Research and the Bureau of Medicine and Surgery of the U. S. Navy, was completed a year ago, but continues to be tested in actual utilization for possible revision and for reexamination of the process of its production and pre-release audience testing. A book, "Infant Development" (Subtitle: "The Embryology of Behavior in Pictorial Outline"), has been published by Harper's as a reference volume to be used with the film. The film was recently accepted for showing at the medical section of the Edinburgh Film Festival.

A new motion picture, "A Concept of Maternal and Neonatal Care," was produced in conjunction with George Washington University School of Medicine. It offered additional experience in the processes of medical film production and pre-release audience testing. The film was completed in August 1951. A fact sheet to amplify the film contents is in preparation.

Assistance in special aspects of production was given to the National Broadcasting Company's "American Inventory" experimental television program in adult education supported by the Alfred P. Sloan Foundation. Two programs of medical subject matter were provided with research and script: "Panic and Morale in Civil Defense," July 22, and "The Costs of Medical Education" (working title) for October 28.

Consultational and script assistance was given to the U. S. Public Health Service and Film Documents for a film report on the hospital facilities program tentatively entitled "The Community Hospital."

Distribution: The goal of effective distribution is to have good audiovisual materials easily available to teachers and students when they need them. The role of the Institute at this time is conceived to be a contributory one: to discover how best to achieve this result for the medical colleges and to implement those findings.

The Institute has been assisting in the establishment of two medical professional film libraries serving geographical regions. In conjunction with the Medical Society and the Department of Health of the State of New York, the Institute has aided materially in appraisal and cataloging of an initial stock of films handled by the Office of Health Education in Albany. In Boston the Massachusetts Medical Society and the Postgraduate Medical Survey, which include the medical schools of that city, have begun preliminary film appraisals leading to the establishment of a similar regional film library based on the experience of the former.

The Institute has been engaged in a pilot experiment in the reproduction and sale of unusually good medical teaching films not generally available, or only at prohibitive costs.

Contributions to the distribution abroad of good American medical films have been effected through recommendations to the U. S. Department of State for the International Motion Picture Division, and by contact with the purchasing missions of several foreign governments.

Utilization: The chief purpose of the Institute in the field of utilization of audiovisual aids is to assist the medical teaching profession in developing the disciplines of the several visual languages, and to further the supply of adequate equipment to carry out those disciplines. The Institute has assisted in developing an audiovisual study room in conjunction with the library of the New York Medical College to explore the problems and solutions of making audiovisual materials available to medical students for out-of-class study.

With the Washington University School of Medicine, the University of Missouri School of Medicine and the New York Medical College, preliminary trials were begun with utilization of motion pictures

for the teaching of social and environmental factors of medicine.

Training: The Institute staff believes that the demand of the medical colleges for acceptable audiovisual tools presupposes talented medical scientists trained intensively in the media of mass communication and devoted to the purposes of medical instruction. To this end, all functions of the Institute are partly designed to discover, train and provide experience and positions for such talented persons. Men skilled in medicine, education and audiovisual media will transform the present chaos of medical audiovisual education into an orderly and creative plan of use of the splendid modern media of human communication.

A full-time working fellowship has been devised, comprising formal university schooling, reading, film analysis and study, and limited practical experience. The fellowships are in evolution as the Institute expands. Dr. John L. Meyer II has completed the first fellowship. Dr. Floyd C. Cornelison Jr. has begun a second.

Reviewers in the film evaluation program have been given informal training in film pathology. The expert review panel personnel also have gained new insight into the anatomy and pathology of the present teaching films.

The staff, through its real experience in consultation and production, has learned a great deal. With lengthening experience, the Audiovisual Committee and Advisory Committee have become more progressively informed of the problems that are inherent in developing audiovisual tools in medicine.

Summary: Within each area of its broad six-point program of work toward the improvement of medical audiovisual aids, the Medical Film Institute has made important advances. The program has widened, the personnel base has strengthened, the prestige of the organization has gained ground, the contributions to medical education have been noteworthy and well worth what they have cost.

Acceptance

The annual report of the Committee on Audiovisual Education was accepted without revision at the Business Meeting, Tuesday, October 30.

Recommendations

The Association approved the following recommendations of the Committee on Audiovisual Education:

1. That the name of the Medical Film Institute be changed to the Medical Audio-Visual Institute.
2. That the program for publication be given impetus in order that the Medical Audio-Visual Institute be of increasing service to the medical schools.
3. That the program of consultation of the Institute be expanded with direct service of increasing volume to the medical schools.
4. That experimentation be carried out in the distribution of three to five films designed for medical school instruction.
5. That the Institute continue to train personnel in the techniques of audiovisual education.

Committee on Environmental Medicine

DUNCAN W. CLARK, chairman: *I. ORIGIN AND BACKGROUND OF THE ASSOCIATION'S ACTIVITY IN ENVIRONMENTAL MEDICINE:*

American medical colleges, both individually and collectively through their Association, have long recognized the significance and values of medico-social teaching. So far as organized activity in this regard is concerned, the Association's Commission on Medical Education in 1932 affirmed the importance of social and environmental factors and of the need to permeate teaching in the clinical course with the concept of medicine as a social agency.

At the 1938 meeting of the Association, a symposium on "Home Visits by Medical Students as a Teaching Asset" was the main feature of the program. The point referred to repeatedly by most of the speakers was that home visiting was a device that provided students an opportunity for studying the patient as a whole. Experience with domiciliary medical care teaching programs were presented as were environmental and clinical-public health case studies. Common to all these programs was opportunity for observation of the physical, social, economic, occupational and recreational environment of the patient. Not in all instances was this the primary purpose of such instruction. In some the intent was primarily the conduct of a program that readily simulated the conditions of general practice for the value this had in the total education of the student.

In 1941 the Association set up a special subcommittee responsible to the Committee on the Teaching of Public Health and Preventive Medicine and charged it with

the obligation of exploring the subject of medico-social teaching. At the next meeting, the chairman, Dr. J. A. Curran, Long Island College of Medicine, reported the result of a questionnaire survey conducted among the member schools, after which the committee was established as an independent body and invited to continue its study.

In 1943 agreement on collaboration was established with the American Association of Medical Social Workers and Eleanor Cockerill, University of Pittsburgh, was appointed co-chairman of the joint committee, with Dr. Curran continuing as chairman representing the A.A.M.C.

In 1944 a Project Committee, under the chairmanship of Dr. Jonathan E. Rhoads, University of Pennsylvania, was formed and given power to formulate policies and plans for the conduct of a Study of the Teaching of the Social and Environmental Factors in Medicine. After selected trial studies to determine the practicability of their methods, approval for a more intensive study was obtained from the parent organizations and a grant in support of the work came from the Milbank Memorial Fund. Harriett M. Bartlett, Massachusetts General Hospital, was appointed executive secretary for the period of the study in 1945 and 1946. Twenty medical school teachers and 12 social workers took part in the project study.

The general aims of the study were: (1) to gather information on the present-day teaching of the social and environmental aspects of medicine, (2) to analyze the data obtained, (3) to evaluate the methods and techniques of instruction in use, and (4) to offer recommendations based on conclusions drawn from the study.

In the course of the study, information concerning 65 schools was obtained by correspondence and 13 schools were visited directly by a study team. The final report of the joint committee appeared in a monograph, published in 1948 by The Commonwealth Fund, entitled, "Widening Horizons in Medical Education." This valuable report has had a wide distribution and, apparently, an important influence on medical education.

With completion of the assignment of the joint committee, Dr. Curran resigned as chairman and a reconstituted Committee on Social and Environmental Medicine was formed. Its name was shortened to the Committee on Environmental Medicine in 1950.

II. COMMITTEE ACTIVITY FOR 1950-51:

Functions: The present Committee on Environmental Medicine conceives its principal function to be the conduct of studies on certain aspects of present-day teaching in social and environmental medicine. In the natural course of such activity, the committee will:

(1) Exchange information with related professional groups similarly engaged in studies of this field, so setting up a two way information and consultative service between such groups and the Association.

(2) Attempt identification and interpretation of trends in research in social and environmental medicine for the relation these may have to the expanding curricular content of this field.

(3) Attempt identification and interpretation of trends in programs and forms of medical care for the significance these may have to such teaching.

(4) Prepare critiques with respect to the problems and accomplishments of medical schools in the teaching of social and environmental medicine together with recommendations thought to be appropriate to its scope of activity.

Meetings: Meetings of the committee were held in Chicago on February 13, and in New York City on September 21, 1951. Much of the work of the committee was, of course, handled by correspondence. It was beyond the capacity of the committee to engage itself simultaneously in all of the activities listed above, and they are listed to suggest the possible range of the committee's function.

Specific Study Projects Considered:

(1) A comparison of those administrative arrangements in medical schools which most easily permit the conduct of instruction in environmental medicine.

(2) A study of the more recent and newer methods employed in the teaching of social and environmental medicine.

(3) Consideration of a conference of those most active in the field of social and environmental medicine. (Special funds would have to be sought for this project. It appeared somewhat unnecessary at that time in view of the proposed 1952 Conference of Professors of Preventive Medicine.)

(4) A survey identifying those schools conducting inter-disciplinary studies where there is collaboration of representatives from the social sciences (other than social work and clinical psychology) with those engaged in medical teaching.

(5) The collection of information on

activities of related groups for the purpose of calling attention to their work as a service to the administrators of medical schools.

(6) An evaluation of audiovisual aids used in this field.

(7) Postgraduate instruction in social and environmental medicine.

(8) Consideration of the methods involved as well as the instructional content of personal health education by the physician.

Decision was made to work on projects No. 1 and No. 5 above.

Study of Administrative Arrangements in Medical Schools which Most Easily Permit the Conduct of Instruction in Environmental Medicine: A letter dated May 7, 1951, was sent the dean of each medical school for the purpose of acquainting him with the proposed program of the committee, and to seek his wish in the matter of whether he or one of his associates would cooperate with us in providing the information needed. The assumption was that in many instances it would be his preference to designate the member of the faculty most active in this field of education as his representative in dealing with the committee. For the bearing this method may have, if any, on the problem of securing information by correspondence and to give a rough index as to assignment of important if not primary responsibility for activity in this field, it is of interest to report that replies were prepared in 13 instances by the deans and in 10 by their administrative associates. Representing the deans in the remaining replies were 29 professors of preventive medicine, five internists, five psychiatrists, one pediatrician and one bacteriologist. In nine other cases deans designated four professors of preventive medicine, three internists and two psychiatrists from whom replies had not been obtained at the time of submission of this report.

On June 20 a letter was sent to the dean or his representative inquiring about the settings in which the teaching of social and environmental medicine is conducted. The information sought is outlined in the following excerpt taken from the letter:

"Our committee is interested in obtaining information about the administrative arrangements and settings in which the teaching of social and environmental medicine is conducted in medical schools today.

"Such teaching usually has as its objective the general purpose of having students understand the significance of social and environmental influences in their case studies for the value this may have in patient care and, further, that through this and other educational experience they may grasp the concept that health and disease are dynamic expressions of the relations of man to his environment. These objectives, directly or indirectly, can be said to concern all departments of a medical school.

"The strong feeling exists that the degree to which these objectives are realized is considerably less than that thought desirable.

"It is assumed that one reason for this partial failure resides in the difficulty of bringing the student into a position where he may observe the patient in the latter's natural environment, particularly the home.

"The purpose of this inquiry is to collect information about the variety of administrative arrangements, particularly those of recent innovation, which may favor achievement of the objectives listed above.

"By 'administrative arrangements' is meant those adaptations of programs of medical care which, for reasons of medical service, or to fill a teaching need, or in the conduct of a research project aid by creating a situation in which the student has a maximum of direct access to knowledge about the patient's environment. Direct knowledge of environment implies entree of the student to the natural environment of the home and preferably contact with the family. Introduction of the student to a patient's home may derive from an extension of medical services (e.g. home care programs; comprehensive medical care for home, hospitalized and ambulant prepaid insurance subscribers; group practice arrangements, etc.), or it may come from special arrangements in teaching or research.

"It is our assumption that the variety of administrative arrangements, the experience with them, the identity of schools trying experimental programs, the possible adaptability of some of these arrangements to the situations of other medical schools—that such information may be useful to the administrators and faculties of medical schools. There may be obtained as well a cross section of some of the current practices in medico-social teaching and a suggestion of recent trends.

"Consequently, it will be very much appreciated if the following types of in-

formation could be placed at the disposal of this committee:

"Description of those administrative arrangements at your college which aid in the teaching of social and environmental medicine.

"Identification of these as having their origin primarily in programs of medical care, or teaching, or research.

"Description of the role and degree of participation of the student in such programs, particularly in the study of families.

"The role of departments of preventive medicine and public health in such instruction."

Analysis of Replies: The replies received were in most cases reduced to reasonably common and uniform terms, but it was decided not to report in this fashion since, in the act of paraphrasing, too many errors were likely and a fair or full picture of each school's program would not be possible.

Some schools will be mentioned to illustrate certain forms of educational activity. It should be made clear that such reference does not imply that this is the principal medium of their approach to the subject under discussion. The purpose of the report is to unfold the pattern and directions education in this field is taking.

No conclusions will be drawn since this is a preliminary report and those schools which have not responded as yet may wish to do so. A final report also should discuss the possible relationships of certain observable trends.

By reason of the particular question selected for inquiry—student participation in medical care in the home as a device for learning social and environmental medicine—there is in most instances necessarily implied a case—project type of approach. There are others who doubt the wisdom of this in favor of teaching as a routine and regular practice the integration of social and environmental information in the total study of each patient in the hospital setting, where the student is most easily supervised. This practice is, or should be, the ultimate objective of all clinical teaching. The argument against home visiting is well expressed in the following comment from one of the schools:

"The department of medicine for many years has emphasized the significance of considering the patient as a whole. This has been taught to the clinical clerks on the wards as they take histories, with special exercises on psychosomatic medicine under psychiatric supervision. The students (and interns) are expected to go into the social and environmental factors in considerable and appropriate detail. It is not necessary at the undergraduate level to visit the actual homes of the patient to learn objective physical situations. The patient's description is adequate. The heart of the problem is the patient's reaction to his environment. This is obtained by carefully supervised history taking, both by internist and psychiatrist. The students are expected to talk with such friends and relatives whose relationship to the patient may seem important.

"When it is necessary to make physical rearrangements of the patient's life, it is important to understand modern methods of physiological appraisal, and the available time should be spent in learning them rather than visiting the patient to climb stairs that could be described in highly quantitative terms by some member of the family or, indeed, the patient himself.

"To help with the emotional setting, it would be more constructive to talk over the patient's conflicts with an instructor who understands something of the dynamics of the emotions than to take a two-hour trip to have tea with the patient's mother.

"In all clinical work, both on the wards and in the clinic, a well-trained social service worker is available for investigation of the environment of the patient. Conferences with the students on such matters are routine."

A different point of view is implied in the significant number of schools that regularly offer opportunity for direct entree to the homes of patients and their families. Still another defense of the concept of teaching "extra-hospital" medicine is summarized in the teaching approach of Dr. John Paul, professor of preventive medicine at Yale (Yale *J. of Biol. and Med.* 22: 199, 1950).

Dr. Paul expresses the opinion that preventive medicine may be developed best as an academic discipline in a medical school through the avenue of clinical epidemiology or endemiology. These are the modern terms which describe the ecology of human disease; that is, the circumstances under which any disease or injury occurs.

". . . if one is willing to study the circumstances under which a given disease occurs, one should be in a better position to prevent it, according to the clinical

principle that treatment logically follows diagnosis. This ecological approach to medicine is timely since during the past generation medical practice and clinical instruction in medical schools have come to be centered in hospitals. Modern medicine, having become more and more a hospital activity, demands that the apprentice work of third and fourth-year medical students be almost entirely concerned with sick people in a hospital bed or sick people in the dispensary. These sick people are isolated 'specimens.' They are segregated from their environment, removed from the circumstances under which they became ill, separated from their families, stripped even of their clothes—all of which is done to create a proper atmosphere for diagnostic study and careful management on the physician's part, free from outside distractions. It may be trite to point out that these outside 'distractions' are the very things which the modern doctor, or the student interested in preventive medicine, needs to study also. If one is to handle patients adequately, it is necessary to bring clinical judgment to bear not only on the patient, but also on the circumstances under which his illness arose.

"There is nothing particularly original about this. It is and has long been the heart and soul of family practice, but it has been gradually eliminated from hospital practice where analytical techniques for the examination of the patient or of specimens have come to dominate the field of internal medicine. A plea for this 'return to the soil' attitude may sound like a plea for a 'dead' period in American medicine such as the one which occurred in Germany at the beginning of the eighteenth century—a period with a poverty of observation and a wealth of speculation. Possibly so, but I would regard it as a plea for a more comprehensive or integrative type of medicine in preference to the analytical approach so popular in the past decades. That American medicine needs something of this type has been expressed elsewhere.

"And yet one might well raise the question here as to whether the need for relating the patient to his native environment and all its attendant circumstances has not been the very thing which has brought social service departments into being in most good hospitals, and, I presume, all teaching hospitals. Such departments have proven indispensable, but a point I wish to make is that the existence of a local department of social service in a teaching hospital does not relieve academic clinicians of their responsibilities regarding 'extra-hospital medicine.' Physicians cannot put the whole responsibility of social medicine in the hands of lay social workers."

Data: Of the 64 schools participating in the inquiry, 29 report the regular, required practice of students visiting the homes of patients and their families. Some have multiple exercises of this type. Nine schools are nearing the point of instituting such programs, some of them quite ambitious in scope. Still other schools have elective programs or home visiting as an inconstant feature, and only 19 schools report that there is no visiting to the homes of patients. Even among the latter are some who arrange for home visiting as a demonstration of the function of public health personnel such as the visiting nurse. These have not been included in this analysis in favor of limiting consideration to situations where a student-patient relationship is developed.

Also reported by several schools are their instructional programs in community health activities. Since these were an inconstant feature of the replies received, comments will be restricted to a few selected cases.

There were virtually no replies to the question concerning adaptation of programs of medical care conducted for reasons of research in which medical students might have opportunity for direct participation.

The most striking feature of the replies received is the apparent degree of current interest and activity in the teaching of social and environmental medicine. There have been many recent changes in the approach to this subject since publication of "Widening Horizons in Medical Education" in 1948.

The information collected will be presented under the following headings:

1. Role of professional staff in social and environmental studies.
2. Status of students in extra-mural studies.
3. Duration of extra-mural case study projects.
4. Administrative arrangements (sponsoring departments).

1. Role of Professional Staff:

(a) Physicians—The usual supervisory functions of the physician are so obvious as not to require elaboration. In the domiciliary medical care programs there is an increasing trend in the use of resi-

dents, both general practice and specialty type, and of fellows.

(b) Social workers—The activities of the medical and psychiatric social work associations in inquiring into their own roles in such instruction is reported elsewhere. Medical social workers cosponsored the study that culminated in publication of "Widening Horizons in Medical Education."

Many schools reported the active participation of social workers in the selection and assignment and co-supervision of students in their daily case studies and in the special projects as well. The full range of the kinds of teaching exercises in which social workers participate is best described in the section of this report dealing with the activity of the American Association of Medical Social Workers.

Visiting nurse—In the main the visiting nurse participates in teaching by taking students on her daily rounds for the dual purpose of demonstrating her function and relation to the medical care team and, secondly, to reveal either the common or the more serious social and environmental conditions to be found in homes.

Certain extensions of her usual function were mentioned. At one school the nurse reports her observation of the student's manner and acceptance of the problems in the home, the degree of his interest and his reaction in general. At Southern California the nurse introduces the student to the patient in the home for the purpose of examining and studying the role of environmental and social factors as they contribute to illness. At one institution the members of the visiting nurse service, through their contact with one or more members of an indigent family, recruit the entire family for a complete medical and social diagnostic study by students under the direction of college staff. The subsequent recommendations for continuing care are implemented by the nurses through the ordinary channels available to indigent patients.

2. Status of Medical Students:

As is well known in hospital practice, clinical clerks are commonly addressed as "doctor" by patients. This designation is less acceptable in an extra-mural situation, particularly in instances where the student has not had much prior contact with the patient; in cases where continuity of contact is to be established there is a tendency to introduce the student with a definitive title which describes his status in terms of a useful function. A term increasingly employed is "family health advisor." This title makes clear that the student is not a medical practitioner to the family, but has only an advisory function concerning the health promotion and protection of the family. What advice is offered is, of course, under faculty supervision.

At Cornell two-thirds of the third-year class elect to serve as family health advisors to designated families over a period of two years. Each student makes a careful study of the social and economic situation of the family: housing, nutrition, sources of income and, particularly, their medical needs. The student works under close supervision of a faculty advisor and has the social and medical resources of the community at hand to aid him.

At Pennsylvania each year an increasing number of first-year students are permitted to elect a four-year experience in which each serves as family health advisor to a selected family willing to cooperate in the program. In this function the student is there to guide the patient through the intricacies of the more complex aspects of medical care, inform the clinic physician of his observations in the home and aid in the interpretation of medical recommendations made.

In some schools, particularly those that sponsor domiciliary medical care programs, the student is spoken of as having the "status of a general or family doctor." By this is meant that he is a junior associate in the medical care of indigent patients who are the responsibility of physicians who also visit in the home and who usually have dual appointments with both the school and the local official agencies cosponsoring the medical care program.

A designation permitted in the Commonwealth of Massachusetts is that of "medical assistant." Students who are at least 21 years of age, have completed two years of their medical course and are under the direct supervision of practicing members of the faculty may be licensed as medical assistants. Boston University fourth-year students are so licensed in order to participate in the domiciliary medical care program.

One other type of function in which the medical student may see extra-mural service is in health education. Fourth year students of the College of Medical Evangelists visit homes in the recruitment of people living in a designated section of the city for the purpose of forming health

study clubs, a project sponsored by the Los Angeles health department. Many of the educational sessions of these clubs are conducted by the students themselves.

3. Duration of Extra-Mural Case Study Projects:

If case study projects may be regarded as long-term when the duration of the student-patient relationship is in excess of one year, then there are relatively few opportunities of this type in the medical schools. Such experience is, of course, difficult to arrange but there seems to be much value in the very length and nature of an extended relationship.

Only two schools appear to provide as a requirement for every student a continuing contact with a patient in excess of one year. There may be other institutions, but if so it is not clear from the replies submitted. Each third-year student at Boston University is assigned a family from the home medical service which he follows for two years. The families chosen include at least one member with a chronic illness and several young children. A full discussion of this highly developed program can be found in the November 1950 issue of the *Journal of the Association of American Medical Colleges* by Dr. Henry J. Bakst.

At the University of Washington each student is supervised in a medical-social case study by a clinician holding titles in internal medicine and in public health and preventive medicine. After the case has been followed for approximately a year with home visits and visitation to the appropriate community agencies, the case is presented during the public health and preventive medicine externship in the fourth year.

The family advisor programs of Cornell and Pennsylvania, which were mentioned above, do not at present involve all students in a class. The majority of the Cornell students have a continuing contact with a patient and his family over a span of two years. The remaining third of the class performs a community survey. At Pennsylvania successively larger segments of the first-year class are permitted to enroll in the elective four-year family study.

A significant fact is the beginning of a trend to the assignment of students to patients for long periods, in some instances to entire families. This year there will be a new ambulant and home care service started at the University of Colorado in association with the Department of Health and Hospitals of the city of Denver. As this program develops, third and fourth-year students will be able to establish a continuing relationship to individual patients and their families for extended periods. In Buffalo, in the present academic year, there will be introduced a program permitting a two-year continuing observation of a patient and family by each student. The latter program involves an arrangement in which case material is drawn from affiliated hospitals with primary responsibility of the program charged to the college department of preventive medicine and public health, the other clinical departments cooperating.

In the near future programs permitting extended contact are planned at Minnesota, Kansas, Albany and Vanderbilt, among others.

At Minnesota, faculty approval has been given to an elective course to be sponsored by the department of psychiatry in which students, nearing the end of the second year, will be assigned to a patient in the prenatal clinic for the purposes of observing the course of pregnancy followed by attendance at the delivery and continued observation of the mother and the newborn child through the remaining portion of the medical course. The basis of the student contact would be in the role of family health advisor.

Kansas plans the development of a division of social medicine within the department of public health and preventive medicine in the supervision of two-year-long family studies. A third and a fourth-year student will serve as a team of family health counsellors to selected families residing in the local community who meet the requirements for participation. The department of public health and preventive medicine will be primarily in charge of the program with the other clinical departments participating.

At Albany there is proposed a comprehensive family study for each clinical student with personal continuing contact with a medically indigent family for a period of two years. This project is to be conducted cooperatively by the departments of preventive medicine and public health, psychiatry, medicine and pediatrics. The central objective is to prepare future medical practitioners to relate the health status of the patient to the social and emotional factors which contribute to positive health or to those which accentuate an existing disease state. One novel aspect of the proposed program is the

working relationship to be developed with the public schools and their school health staffs. In this connection the student will be expected to follow through in consultation with the school physician, the school nurse and the teacher whenever specific health problems and the family environment appear related to the unsatisfactory performance of a child under observation.

Vanderbilt plans to initiate a method of teaching whereby students are introduced to a patient in the family group in the latter's environment during the student's first year, with continuance of these contacts and experiences throughout the four years.

4. Administrative Arrangements (Sponsoring Departments):

The central point of the inquiry concerns the administrative arrangements which aid in the clinical instruction of students under extra-mural circumstances. The administrative arrangements in question have to do particularly with access to patients and their families in the natural environment of the home. These range from the simplest situation of a student making a prearranged post-hospital call to the more complex inter-departmental teaching projects of domiciliary medical care conducted as a shared responsibility with other community agencies for medical care. Since in each instance these arrangements must be initiated and maintained by a unit of the school, this matter will be considered from the point of view of the sponsoring department. Reference also will be made to the programs of some schools where home visiting by the student is inconstant or even negligible but where new inter-departmental arrangements aid in the complete study of the patient.

(a) Office of the Dean—It is not entirely clear either from the letters of reply or from the medical college catalogues, but the impression is gained that in several institutions the dean and not one of the academic departments is responsible for administration of instruction of the preceptorial type. This seems to be identified with his executive function, even in instances where he also holds an academic title. In view of the nature of the association and to the necessarily scattered assignment of students to the general practitioners serving as preceptors, it seems logical that this arrangement should prevail.

Preceptorships are generally organized to demonstrate general practice, to recruit to it and to give a picture of the social and environmental aspects of medicine seen in the home as observed through the eyes of the family doctor. The duration of preceptorships ranges from four to 11 weeks, and the experience is usually offered fourth-year students. A striking exception is South Dakota which organized clinical clerkships for second-year students through assignment of the latter to general practitioners for one month. This experience was reported by Dean Slaughter in the *Journal of the Association of American Medical Colleges* 24: 193, 1949.

Vermont and Wisconsin are among those having the longest continuous experience with preceptorial teaching. There is an increase in interest in preceptorship training with Kansas, Oklahoma, the University of Washington starting these programs in recent years. The Stritch School of Medicine planned to begin in the current academic year the practice of assigning one-third of the senior class to the offices of general practitioners attached to a school affiliated hospital.

(b) Medicine and Pediatrics — These clinical departments either alone or cooperatively with others frequently arrange for individual case studies that involve consideration of the family and home.

At Rochester, students in recent years in the department of medicine have been asked to study a single patient in considerable detail in order to determine how the patient's illness might have been prevented and what measures could have been taken for better management. This always involves contact with the patient and the family in the setting of the home.

A similar arrangement prevails at Ohio State and Stanford in pediatrics. Such experience permits the student opportunity to form some understanding of the environmental influences which may alter and change the course of the child's condition. These include consideration of the social, community, parental, economic and hygiene factors. There is interest in helping the student understand the interplay of the various forces and factors which tend to mold the child's life.

The most complex type of administrative arrangement, namely the operation of a program of domiciliary medical care, is frequently the charge of a department of medicine and this will be discussed under another section.

(c) Psychiatry—The past decade has witnessed the movement of psychiatry to

a prominent place in medical education. In this development there is an increasing consideration of the emotional problems of the nonpsychotic patient. More and more, psychiatry instructs jointly with or on the premises of other clinical departments, sharing in the same teaching material. Examples of this are seen in the programs at Southwestern, Duke, Hopkins, Woman's College and Minnesota (mentioned above).

At Southwestern, under the direction of psychiatry, a course is offered in the art of medicine. This is a supervised experience in which each second-year student is given a limited responsibility for two patients over one-half of a one-month period. The student's function is to coordinate the available medical information usually obtainable from a variety of sources in the interests of these patients. He is charged with summarizing what has been accomplished, what apparently remains to be done, what coordination of recommendations is desirable and whether there are any misunderstandings or misinformation that need be corrected. It is the job of the student to know the family and home situation so thoroughly that he can aid in the judgment of whether the medical care ordered is practical in terms of the actual situation in which the patient lives. The students are surrounded with all facilities needed for the care of patients, but the initiative is left to them. They are expected to meet the needs of these patients in the period of the study and to be available at all hours as any doctor would. The intent is not to teach psychiatry but an attitude toward people—how to approach patients, how to establish a good relationship. Preparation for this comes in prior lectures and case demonstrations.

At Duke there has been in existence for about four years an experimental program in defining and infiltrating a comprehensive approach into the routine medical practice of a teaching hospital, as well as testing the instructional methods of highest validity in this approach. This is done through operation of a comprehensive medical clinic in the medical wards and outpatient department by a psychiatrist director, three fellows in psychosomatic medicine, three psychiatric social workers, two medical social workers, two psychosomatic nurses, one of whom is a public health nurse, and a clinical psychologist. The group's experience and conclusions to date are published in the *North Carolina Medical Journal* 11: 615, 1950, by Dr. M. H. Greenhill and his associates. This article points up several pertinent aspects of this subject and certain of their thoughts are abstracted or quoted below:

Comprehensive medicine is held to be a method of recognizing and treating all the physical, social and emotional variables which are an integral part of the processes of health and disease in their order of relative importance. These processes must be considered in terms of the relative values of the several components of the living organism. These components include physiological and biochemical factors, symptom manifestation, mechanisms of adaptation to stress, inter-personal relationships, and social and emotional stimuli and reactions.

The problem of such teaching is a difficult one in medical schools at the present time because of preoccupation by instructors with the physical manifestations of disease. The approach of many teachers is apt to be a monistic one of simple cause and effect. They lack a multi-dementional approach, and the other two variables—the social and emotional — require consideration of three areas instead of one. A reaction of insecurity appears even among the teachers when they find that in many cases the physical area is no longer the supreme value and is even distorted and made relatively less valid by the influence of the other two areas upon it.

"In recent years teachers of preventive medicine and public health have made important contributions to the knowledge of comprehensive medicine. These contributions have been mainly theoretical in terms of the development of concepts of social medicine. Emphasis has been placed upon the importance of the study of health as well as disease, and on the influence of social pathology upon health and disease. But in such an approach the emotional components have been relatively neglected, and knowledge of the individual has been sacrificed for an approach to the group. Social medicine, therefore, has not achieved comprehensiveness in its practical function, although theoretically the individual and the variable of his emotions have been considered. Departments of preventive medicine and public health in a very few schools of medicine incorporate the concept of the theory and practice of social medicine in their curricula, but this is, in the main, an unachieved ideal."

The segmentation of the disciplines of

medicine has led to assignment of this phase of teaching to the psychiatric curricula of medical schools. Psychiatry, dealing as it does with so many obvious social and emotional problems, has been the first of the clinical disciplines to develop techniques for their handling. There is no basic reason why psychiatry alone should attempt to be the only discipline to handle them. "This concept is leading to a reorientation in medical education. Impetus is given to this by the increasing awareness of the necessity of considering the social and emotional components in the disease process of every patient and of the wisdom of dealing with the patient by a holistic approach. Hard reality, outlined by statistical evidence, adds pressure to the necessity of infiltrating a more comprehensive approach into the diagnostic techniques and treatment skills of all types of medical personnel, in addition to those being trained in the psychiatric disciplines. There are not now, and it seems unreasonable to expect that there will be in our lifetime, enough psychiatric personnel to take responsibility for the management of the emotional problems of sick individuals. The trend now is to train non-psychiatric medical personnel in orientation and techniques to be utilized in the evaluation and management of such patients. Such a trend is designed to prepare general practitioners of medicine, hospital nurses, public health officers and nurses, and specialists in other disciplines of medicine to perform a triple task; namely, that they themselves deal with minor psychiatric problems, evaluate and manage the emotional and social components in any patient with any disease and, finally, contribute to the maintenance of the emotional health in patients and their families. It is obvious that many problems take root here. For example, is it possible for non-psychiatric medical personnel to perform these functions; what are the limitations of these roles; and, finally, how can these functions be taught with the limitations of time imposed on such education and in face of the emotional resistance which non-psychiatric medical personnel raise against such an orientation?"

So far as the instruction of undergraduates is concerned, the comprehensive medical group begins with one quarter of the second-year class. Twenty hours of instruction is given to this part of the class in physical diagnosis. This same segment of the class is followed in the third and fourth years, having a variable number of hours of instruction in optional group conferences and in individual supervision. The entire third and fourth-year classes are given approximately 14 hours of instruction by the comprehensive medical group in small groups during clerkships in medicine.

Johns Hopkins School of Medicine carries on in the medical clinic an interdepartmental teaching program in which the social, environmental and economic aspects of illness are stressed. Certain features of the administrative arrangements employed are of interest. These include the group practice type of organization of the outpatient department; sponsorship of the course as a joint venture of the departments of preventive medicine, medicine and psychiatry, an integration which is aided by the practice of academic appointments in all three departments for key personnel together with financial support from all three departments. The optimal time in the curriculum for such instruction is thought to be that part of the medical course where the student first encounters responsibility for the care of patients in the outpatient department. The group practice nature of the medical clinic has favored the development of the role of social workers as major therapeutic agents to an important degree. Each student completes a single, intensive, major case study in which visits to the home are optional. Discussion seminars and case presentations are employed to bring out the significance of the major and more important social and environmental problems in medical care.

Woman's Medical College of Pennsylvania has three arrangements permitting access of the home to the student. One of these involves a comprehensive study of a patient on the medical ward in which special emphasis is given the psychosomatic components. A full-time psychiatrist serves as consultant to the student in the course of the study, and visits to the home and family are made in the company of a social worker.

Preventive Medicine: The designation preventive medicine is used to identify all academic departments representing this area of instruction, whether known by those or other titles, and whether combined with public health or any other department.

Of all the units of the school concerned with instruction in the social and environmental aspects of medicine, preventive medicine appears to be the most active.

It is obvious that this should be the case in view of the usual responsibility of this department for presentation of community health problems and activities; also, teachers of preventive medicine are the more ready to consider and view people in their native environment. Of more significance is the apparently increasing rate at which preventive medicine is assigned responsibility for conducting case studies and demonstrations, or for coordinating a teamwork approach to the complete study of the patient, with special emphasis on the social and environmental aspects.

The dilemma of preventive medicine has been and in some areas continues to be that of difficulty in access to patients for a department where the need is recognized of incorporating in their program an experience involving personalized clinical preventive services. This has the most meaning to a student when it is part of a comprehensive approach in case study.

In overcoming this difficulty an interesting variety of administrative arrangements have been developed which permit the teaching of preventive medicine at a clinical level.

For purposes of discussion, it is possible to consider these arrangements in two categories: (1) situations where departments of preventive medicine have direct access to clinical material as found in the clientele of health departments and other community agencies, and (2) situations where the clinical material used in illustration of the teaching of preventive services has its origin in teaching hospitals.

Several departments of preventive medicine sponsor clinical clerkships, and a common practice is to assign students to health department clinics for the opportunity of observing the personalized health services provided by such agencies. The breadth and variety of teaching material would seem to vary with local community organizational practices since in some the functions of health and hospitals are combined in a single department. This seems implicit in the titles of the local official agencies but may have no meaning since it was not discussed particularly by those responding to the inquiry.

While the patient material seen in a health department clinic is most useful for demonstration of programs of communicable disease control and of the maintenance and promotion of health through maternal, child, nutrition and other clinics, the specialized nature of the medical service offered may at the same time limit the degree to which patients may be used for purposes of comprehensive case study. This may be one explanation of the frequent use of hospital clinical material in special medico-social case studies in preference to that available in the health department where college preventive medicine is associated and may be physically housed. Other apparent reasons for choice of hospital clinical material may be the relatively more complete backlog of information already available in the record of the previously hospitalized patient.

One example where health department clientele has been used as a source for comprehensive case studies is at the State University at New York City. To meet the teaching need of access to entire families, an extension of the function of the visiting nurse was devised in which selected indigent families having many medical and social problems are recommended by the nursing service for evaluation by the college department. The student is introduced in the home by the visiting nurse, and he obtains through repetitive visits as complete information as possible of the medical and social status, relationships and needs of each member. Each student is supervised by an internist and also available for student consultation are a psychiatrist, pediatrician and obstetrician. A social worker arranges for personal contact for the student with community agencies having present or past contact with the family. Definitive recommendations for therapy and continued care for the family are implemented, with the advice of the social worker, by the visiting nurse through the usual agencies for medical care available to indigent patients in a large city.

Rather few institutions report the assignment of students to the study of ostensibly well people. Opportunity for this seems implicit in any situation providing extended contact with families, especially in the domiciliary medical care and family advisory programs. The University of Pennsylvania reports that in their four-year family study the element of health maintenance is being introduced. Jefferson Medical College reports that its department of preventive medicine is associated with a unit of the health department which has a program catering to apparently healthy persons. It is known as the Health Maintenance Clinic and to

an increasing degree members of family groups are seeking the service of this clinic. Students act as clinical clerks, performing health examinations, and a detailed study and inquiry into individual behavior and environment are included. The Health Maintenance Clinic is being used as an experimental laboratory in the study of procedure in the examination and care of the healthy person.

At Tulane, third-year students are assigned to a preventive medicine clinic for the purpose of studying the ostensibly well person with periodic group discussion of the patients examined and inclusion of reference to the social aspects involved.

Among other phases of its program, Wisconsin reports two features that are somewhat unique. For a limited period senior students participate in the medical care and health advisory functions of the University Student Health Service. This, of course, encompasses a group of essentially healthy young adults and a type of clinical and social problem different from that encountered elsewhere in the medical student's experience. Another feature is adjustment of schedules permitting participation of students in epidemiologic field studies depending upon the time of occurrence of specific situations in the field.

Schools in addition to some of the above which use health department clientele for social and environmental case studies are State University at Syracuse and the University of the Philippines.

At State University at Syracuse, the student is assigned a case record from the files of the Syracuse Department of Health with responsibility for collecting full information pertaining to this patient. In the course of working up the data for presentation to the class, visits to the home of the patient and to the various community agencies are involved. At the University of the Philippines, students visit the homes of selected patients registered in the clinics of the WHO-UNICEF Rural Health Demonstration and Training Health Center Program at Quezon City. In addition to this medical-social study, each student is required to complete a sanitary survey of the community where he expects to practice medicine.

Cincinnati, Albany and the State University of New York report programs that involve the use of community agencies in the instruction of preclinical students, each for somewhat different purposes. Beginning in 1939 and continuing to the present, an extra-mural program in preventive medicine and public health has been conducted for second-year students at Cincinnati; 120 hours are assigned for this purpose. Visitation to a wide variety of community health activities are the essential feature of this program. The areas covered in these field trips require consideration of the social and environmental aspects of medical care, significant environmental factors, etc. A monograph describing this program was published by Dr. Alfred Korach in *The Medical Bulletin of the University of Cincinnati*, Vol. 9, October 1942.

At Albany, for the purpose of developing attitudes and understanding on the part of students conducive to cooperation with social work agencies and to stimulate interest in the social and familial backgrounds of patients, there has been established a new type of course for second-year students. Each student spends nine to 11 half-days observing in one of the official or voluntary health and welfare agencies. After sufficient orientation, students are assigned places on the agency staff and are permitted to carry on some elementary social work activities.

At the State University of New York, a limited number of first and second-year students may elect assignments to family social agencies and participate in the solution of short-term problems of selected families. The purpose is not to acquaint students with community agencies but to provide experience in the art of establishment of a professional relationship. The family agency is chosen as a locale in which the beginning student may be supervised in a situation where he has the status of a participant in the care of someone under stress.

In order to obtain access to the clinical material found in hospitals and to teach in cooperative association with the other clinical departments, the following types of administrative arrangements are employed by departments of preventive medicine:

(1) Instruction of students on the time assigned to other clinical departments. For example, at Colorado, among others, staff from preventive medicine teach directly in the wards and clinics of other departments.

(2) A system of dual appointments for preventive medicine staff in one of the other clinical departments. This has been described above in the examples of the University of Washington, Johns Hopkins, etc., and is a well known practice.

(3) Clinical appointment in multiple hospitals for the professor of preventive medicine. For example, in the plan of reorganization of the department of preventive medicine at Harvard in 1947, it was recommended that there be sought more integration of the teaching of preventive and curative medicine and the medical sciences. A practice which facilitates accomplishment of this purpose is the award of medical appointments to the professor of preventive medicine at several of the hospitals affiliated with Harvard so that in ward rounds and conferences the preventive point of view and the significance of environmental factors may be stressed.

(4) Administration of preventive medicine as an integral part of internal medicine. This is the case at Yale, the University of Chicago and Southwestern. At Yale, preventive medicine is taught at the patient's bedside and the emphasis is on the contribution of clinical epidemiology in the comprehensive approach to the patient. The procedure employed is the following: in a weekly preventive medicine seminar for third-year students, discussion starts with a critical review of the accuracy of the diagnosis and presentation of what is known about the epidemiology of the disease in question. If possible some pertinent data are shown, either on a lantern slide or in tabular form on a blackboard, to indicate certain known circumstances under which the disease in question usually occurs, together with a listing of the various factors thought to be of etiologic importance or of importance as predisposing elements. The past history of the patient is then reviewed step by step in the light of the epidemiological data; the patient's present condition is reported and the prognosis discussed. These are reviewed at length before the attempt is made to predict how the situation which led up to the patient's illness might have been altered, how the situation should be handled from the standpoint of prevention after the patient leaves the hospital, and how a similar situation with another potential patient could be handled.

The University of Chicago is gradually enlarging its preventive medicine staff and greater use of the outpatient department is planned in the teaching of social and environmental medicine. The functions of the division of preventive medicine at Southwestern are changing, as will be reported below.

(5) Interdepartmental teaching in which preventive medicine is a participant is a common practice. In some of the formalized arrangements mentioned above, cooperative teaching is but one of the essential elements. Reference is had here more to interdepartmental teaching without the prerequisite of hospital or academic titles or of any other formal arrangement and where psychiatry, medicine or one of the other services assists in the teaching programs of preventive medicine and vice versa. For example, at Illinois during the outpatient service, senior students are assigned to patients jointly studied by staff from preventive medicine and psychiatry. Each student visits the home and family and completes a study for presentation at a conference attended by representatives from preventive medicine, psychiatry and social service.

(6) Use of the hospitalized or the post-hospital patient for socio-medical case studies. This is one of the more common devices employed by preventive medicine in clinical case study teaching. In most instances such patients have been the object of previous study by clinical departments other than preventive medicine. Washington University, New York University, New York Medical College, Maryland and Buffalo are examples of institutions conducting these case studies.

At Washington University there is extensive teaching of social and environmental factors in the preventive medicine clerkship. The student engages in one or more socio-medical case studies utilizing patient material which he has seen during other clinical clerkships. Students interview the patient and family in the home, representatives of schools and churches and any social agencies with whom the patient may have had prior contact. The student must make an evaluation of the social and environmental factors determining the occurrence of illness and conditioning medical care. By such means he comes to know the impact of illness on the patient, his family and the community. There are 12 seminars dealing with social and environmental factors—four of them devoted to psychosomatic influences as they pertain to medical care.

At New York University, Dr. H. E. Meleney and Dr. H. Mortara have just finished a five-year review of their experience with medical-social family studies. During the fourth-year clerkship, students are assigned in pairs to the study of a family to give the student under-

standing of the emotional, social, environmental and economic factors in the medical problems of patients. In addition to making the student aware of the need of understanding a patient in relation to his family and total environment, the experience also demonstrates the function of the social worker in a medical setting and the use of community resources. The majority of patients come from Bellevue Hospital, and others are derived from four other sources. The medical students review the medical and social service records of the principal patients and visit the home of the family in the company of a social worker. Subsequently, there are field trips to community agencies and consultations with the supervising physicians. A report is submitted and made the basis of case presentation at a subsequent student conference.

At New York Medical College, students visit in the homes of patients of the East Harlem District Health Center and of the Flower-Fifth Avenue Hospitals. At the latter each student is assigned three patients by the social service department of the hospital with summaries and records of the information available. The family is informed that a member of the clinic will visit, and students on their free time visit the home and write up a report in terms of a common guide sheet for presentation at seminar meetings attended by the professor of public health and the social service staff.

At Maryland in the course of conferences conducted by the Department of Hygiene and Public Health, case presentations are made by students on patients derived from the hospital ward service, whose home environment has been studied under the supervision of the social worker of the Western Health District.

At Buffalo, patients derived from the outpatient departments of pediatrics, medicine or surgery will be assigned to students beginning this year for the purpose of a two-year continuing contact and study of the family. Primary responsibility and supervision of the program will be in the hands of the department of preventive medicine and public health.

At Louisiana State, the home visit to a discharged hospital patient required by the department of neuropsychiatry is simultaneously used as an environmental case study by the department of public health and preventive medicine. The student is asked to note and evaluate the public health problems that exist or the environmental and social conditions that may be of importance with regard to potential health problems as well as those presently existing. These observations are all included in the write-up of this visit.

(7) Employment of the case study method as a means to an understanding of the role of community health agencies in medical care and the promotion of health. Stanford, Harvard and George Washington are examples of schools with such programs. The course at Stanford is entitled "The Patient in his Environment" and is described in "Widening Horizons in Medical Education," pages 127 to 135. The objective is to familiarize the students with the responsibilities of the medical profession in the present social structure; the influence which the practitioner exerts on his community, and the social-environmental influences which affect each patient's illness; also, to acquaint the students with the resources or facilities which the community provides in meeting these responsibilities.

Students in groups of three are assigned a patient seen formerly on the wards for complete study. Each case presentation is used as a point of departure for a general discussion of the work of a particular welfare agency, which in turn is related to the work of other agencies in the same field. At times a representative of the agency involved is asked to attend and participate in the discussion.

At Harvard, one phase of the course in preventive medicine involves a survey of community agencies available for medical and health care. Preparation for it comes in a preceding lecture and panel discussion course and this project tests the ability of students to apply the principles taught to the actual care of patients. This is known as a health resources survey, and replaces the former sanitary survey. Four hypothetical cases are chosen which highlight the more common and typical problems met in ordinary medical practice. In each case the student is asked to prepare a detailed quantitative and qualitative statement of the diagnostic, therapeutic and preventive services which should be available for the optimal care of each patient in the light of current scientific knowledge. Having outlined the optimal facilities, the student visits a community of his own choice, possibly one where he may start his private practice, and performs a survey of the facilities which actually exist for the

care of four such patients. This is followed by a discussion of the differences between the optimal and actual facilities and, finally, practical suggestions concerning improvement of existing medical services.

George Washington School of Medicine is introducing this year a health resources survey in the teaching program conducted by the department of bacteriology, hygiene and preventive medicine. The decision to employ a health resources survey as one device for understanding social and environmental medicine appears to have its origin in two circumstances. One is the apparent merit in the teaching method itself, and the other seems to be an administrative adaptation to the fact that at this school the teaching of clinical preventive medicine is an integral part of the functions of each of the clinical services. The department of bacteriology, hygiene and preventive medicine has no direct clinical responsibility, although it does teach at selected clinical levels in demonstration of personalized health services through association with a local but somewhat distant rural health department. The health resources survey apparently is suitable for application either in the immediate clinical facilities in which the medical school operates or in the community where the student visualizes his future practice will be located. It involves considerable community but obviously no home contacts in view of the hypothetical nature of the case histories.

At Cornell, about one-third of the class choose to prepare an extensive survey of the health resources of a community, but this is not done through the medium of actual or hypothetical case studies.

(8) Assignment to preventive medicine of administrative responsibility for ambulant and home care patients. Such programs are about to start at Colorado, Southwestern and Washington University.

At Colorado, in order to realize the teaching objective of training students to give health supervision to families and individuals on a continuing basis rather than as an episodic affair, arrangements have been worked out by the medical school with the Department of Health and Hospitals of the City of Denver. The medical school is committed to the development and operation of training programs for the general physician at both the undergraduate and graduate levels. The city of Denver must provide continuing general medical services to a large portion of the indigent and medically indigent of the city. It was clear that a combination of the resources of the two agencies would be to the mutual advantage of each. This led to the administrative arrangement of the establishment of the general medical clinic in the department of health and hospitals. This clinic will act as a single portal of entry and discharge for the medical care services of the department of health and hospitals, and will replace the general outpatient department of the Denver General Hospital. It will be the administrative responsibility of the department of health and hospitals. Its professional staff will be members of the faculty of the school of medicine and organized as the preventive medicine and public health medical staff of the department of health and hospitals. The chief of this division is to have the title of director of professional and educational services of the clinic and is to be a member of the university department of preventive medicine and public health.

Commencing possibly in the present academic year, there will be an ambulant home care program at Southwestern conducted under the auspices of the division of preventive medicine in the department of internal medicine. At Washington University there is strong likelihood that the department of preventive medicine will be responsible for the professional services rendered in the outpatient department of the medical school coordinating all teaching of ambulant care and providing students with some opportunity for experience in the homes of patients.

Domiciliary Medicine: Schools reporting programs of domiciliary medical care are Georgia, Tufts, Boston University, Nebraska, Vermont and the Medical College of Virginia. Reference has been made above to the proposed programs of Kansas and Colorado, the latter now getting under way.

Georgia has had a long and continuous experience with domiciliary medicine starting a large scale program of home care of patients as a teaching device in 1925. By virtue of a contract with the city and county, the medical school enjoys the privilege of exercising medical and surgical control over all the free patients in the city and county, and is responsible for the choice of the participating physicians. Each student spends a third of his senior year in this program which is operated by the department of medicine. A description of the values in this form of

teaching is found in the article "Domiciliary Medicine at the University of Georgia Medical School," by V. P. Sydenstricker and S. L. Lee, published in the *Journal of the Association of American Medical Colleges* in 1939.

The domiciliary medical service of the Boston Dispensary was established in 1796, and medical responsibility for the work of this service was reorganized under the department of medicine of Tufts College School of Medicine in 1929, at the time of the establishment of the New England Medical Center. The professional personnel supervising the district service now consist of a medical supervisor, six full-time physicians, a group of fourth-year medical students and a full-time social worker. The medical supervisor is a member of the staff of the medical center and of the faculty of the medical school. He is responsible for the administrative and medical policies of the service as well as the teaching program. There are six district physicians who are appointed to fellowships in domiciliary medicine for a period of one year. They spend their mornings in the medical and specialized clinics of the Boston Dispensary, and in other teaching exercises at the New England Center Hospital. Their afternoons are devoted to making home visits to patients and acting as preceptors to medical students. All new patients seen by the students must be checked by the preceptor after which the student may make followup visits alone, reporting the progress of the patient to the preceptor. Eight to 12 fourth-year students are assigned to the district service for a period of four weeks. Their mornings are spent with the medical supervisor and in outpatient work. Each student undertakes a study of the social situation and related factors in one of the cases he has worked up medically. There are seminars which point up the significant medical and social problem.

For three-quarters of a century, Boston University and the Massachusetts Memorial Hospital have accepted responsibility for a domiciliary medical care program known as the home medical service. This was regularly a function of the department of internal medicine until its transfer to the department of preventive medicine in 1948. The home medical service ministers to certain of the medically indigent residing in an area one square mile around the school with a population of about 50,000 residents. In one year recently, there were 11,608 home visits. Senior medical students are legally privileged to practice as medical assistants under the supervision of registered physicians. Each student spends one month on this service and may spend an additional month on an elective basis. The third-year program of assignment of a student to a family has been described above. The immediate objective of the service is to give medical students, just as all departments combine to do in a collective way, an opportunity for full comprehension of the physical, psychological and social aspects of medical care. The program is believed to be a practical answer to the problem of integrating the various phases of the medical curriculum into a unified approach to the patient as a whole. The student is able to see illness at its onset and to get some picture of the varied and inclusive problems of the general practitioner. He sees the patient in relation to others and there is less need to give didactic emphasis to the very obvious social and environmental factors which exist. He becomes familiar in a practical way with utilization of public and private resources, and finally obtains the point of view that medicine is a social as well as a natural science.

For many years at the University of Nebraska there has been operated an out-call service which is part of the dispensary service. Indigent patients may call and have a senior student visit in their homes. The senior student studies the patient and makes recommendations, conferring with a supervising staff man to assist in the problem.

A domiciliary medical care program has been associated with the University of Vermont College of Medicine for the past 15 years. It is known as the city service and is housed in an outpatient department under the direction of the city physician, who is a member of the college teaching staff and devotes full time to this assignment. Senior students are assigned for a period of one month to this service where they are on 24-hour call. In the company of the city physician they visit the city's indigent who need medical care. Complete studies are made by the students who then discuss the situation with the city physician, and arrangements are made for a plan of action in the care of the patient.

At The Medical College of Virginia, a home care program is administered jointly by the Department of Public Health of the City of Richmond and the medical college. In the course of an

eight-week clerkship, senior medical students spend one-third of their time in assignment to a home care program and the other two-thirds in the general medical and medical specialty clinics. Initial home visits are made by medical students in pairs in health department cars equipped with two-way radios. Following the home visit the medical findings are reviewed with the residents or attending physicians, who return with the students to see the patient or make other appropriate recommendations for the care of the patient. There are weekly meetings of the staff in which the patients are discussed, and there are 16 seminars at which the public health, as well as the more strictly medical aspects, are presented in the case discussions of patients, their families and their problems. This is all operated as a function of the department of medicine.

Family Studies: There is a trend toward a study of the family, not alone as a means of inducing students to enter family practice, but to make students aware that the problems of a patient are often not understandable except in terms of knowledge about the family in which he lives.

Over a period of years, as judged merely from changes in teaching emphasis, there appears to have occurred, in successive stages, the concern lest social and environmental factors be ignored in planning medical care, to the stage of recognition of need of an integrated and comprehensive approach which equates social and environmental factors in terms and values comparable to the physical and organic, depending upon individual circumstances. Now there appears to be a movement toward the study of families, an indication of the inseparableness of patients and families. These are, for the most part, patient-centered studies. However, one school assigns families without a principal patient for the value this may have in facilitating study of interpersonal relationships. Such study may at times be impeded by setting up a principal patient relationship with the student or doctor.

There is also a trend in making medical-social studies, whether performed on patients or families, a point of unity for interdepartmental teaching. This seems to be evolving as the natural addition of those skilled in the methods of diagnosis and therapy, plus those competent in handling emotional problems, plus those with a preventive point of view and with competence and interest in the host-environment complex.

The study of families is being developed as a focal point of interdepartmental teaching and of curriculum planning. This appears in the program planned at Cornell. In 1952 there will be introduced a new curriculum of coordinated teaching. One of the clinical clerkships in the senior year will be a half-year in length. Such teaching will be centered in the outpatient department of New York Hospital and will be participated in by medicine, pediatrics and preventive medicine. Students will follow families assigned from the outpatient department to the home. Selected families will be given comprehensive medical care, including home nursing and domiciliary care by hospital staff members.

Among the schools engaging in family studies are Boston University, Pennsylvania, Cornell, New York University, State University at New York City, Buffalo and others, particularly those with home care programs. They are planned in the near future for Vanderbilt, Kansas, Minnesota and Albany.

Communication with Related Professional Groups: (a) Conference of the Professors of Preventive Medicine. Correspondence was initiated with the officers of the conference, Dr. John Dingle and Dr. Ray Trussell. There is no other academic group as primarily concerned with the teaching of environmental medicine as the members of this conference. From this correspondence came an invitation to prepare an article for the June issue of the conference Newsletter entitled "The Social Environment as a Concern of Preventive Medicine." This dealt principally with the activity of the Association of American Medical Colleges in environmental medicine and the relationship of the inquiry on administrative arrangements for such teaching to professors of preventive medicine. Two members of the Committee on Environmental Medicine have been appointed members of the planning committee for the five-day Conference on the Teaching of Preventive Medicine which will be held in the fall of 1952.

(b) For many years the American Association of Medical Social Workers has been actively interested in examination of the teaching function of their members in the medical colleges. Mary L. Poole, University of Pennsylvania, is chairman of the present Subcommittee on Participation in Teaching Social and En-

vironmental Factors in Illness. In January 1951 this committee summarized the findings of a preliminary survey analyzing the variety of ways in which case workers participate in the teaching of social and environmental factors. A questionnaire was addressed to the social service departments of the main teaching hospitals affiliated with medical schools, a total of 74 hospitals. Seventeen report that they are not participating in a teaching program, and many others had not replied at the time of preparation of the preliminary report. Consequently, the information obtained is based on the contributions of 28 institutions.

The variety of programs in which social workers participate include the following: lectures, case presentation for the purpose of seminar teaching, supervision in case study, class discussion, orientation, ward rounds and conferences, consultative function with respect to patients cared for on a home care program, clinic consultations, continuing advisory function to students assigned roles of family health advisors and arrangement for participation in field visits.

Of the 28 hospitals replying to the questionnaire, 10 reported that faculty appointments are given social workers in the medical school. These appointments range from lecturer to associate professor.

Activities of American Association of Psychiatric Social Workers Committee on Medical School Teaching: Psychiatric social workers have been involved actively in medical school teaching for many years. The national professional organization—American Association of Psychiatric Social Workers, 1860 Broadway, New York City—has had a committee on social work teaching in medical schools since 1948. In addition to the national organization there are fifteen district branches of A.A.P.S.W. in various cities throughout the United States, and two additional branches in the process of formation.

Mrs. Melly Simon of the Payne Whitney Clinic, New York Hospital (Cornell University Medical School), was chairman of the committee on social work teaching in medical schools in the academic year just completed. In a study of such teaching, the committee found that psychiatric social workers not only teach in psychiatry departments of medical schools but in others where the teaching of social factors in medicine, of people's motivations, of social resources in general, etc., are incorporated in the teaching program. Increasingly over the past few years, and particularly since conduct of joint meetings of the Psychiatric Social Workers with the American Psychiatric Association, the feeling in the committee has grown that this type of teaching should not be limited to psychiatry departments but should permeate the medical school program, and that this teaching should be shared intimately by both psychiatric social worker and medical social worker. Dr. Thomas Rennie of Cornell University Medical School, and Dr. Howard W. Potter of the State University Medical School at New York, the present psychiatric consultants to this committee, strongly concur in the above.

In 1948 and 1949 the A.A.P.S.W. committee on medical school teaching sent letters to all of the medical schools, principally to psychiatry departments, and a detailed analysis of the first 15 reports received was made. This was done by two Columbia University graduate students in fulfillment of the requirement for a Master's thesis for the Columbia University School of Social Work. Copies of the full report were sent to all the medical schools participating, and additional copies are said to be available for consultation.

One aspect of this report deals with the generic nature of case work knowledge and practice, a feature which was supported by examination of the specific content of teaching done by psychiatric social workers. The report also indicated that a comparison of the teaching content offered medical students respectively by psychiatric and medical social workers would be of interest.

In 1951, Miss Poole of the American Association of Medical Social Workers, and Miss Heyman of the American Association of Psychiatric Social Workers, both on the staff of the University of Pennsylvania Medical School, began a review of the respective teaching settings, via the written material received by both organizations. They hope to select a small group of medical schools where both medical and psychiatric social workers are teaching. Having done this, both organizations hope to proceed jointly with a limited study of the teaching content covered by each group.

Another activity of value to psychiatrists and to psychiatric social workers was the institution of joint sessions of both groups at the 1950-1951 meetings of the American Psychiatric Association for the purpose of discussing certain problems

in the education of the medical student. These meetings have been fully reported and the minutes of the 1950 meeting published in the A.A.P.S.W. *Journal*, Vol. 20, No. 3, 1951. The second meeting's stenotyped minutes were sent to each participating medical school. This meeting dealt with the importance of providing first and second-year students with opportunities to work with people, to develop a feeling for their professional roles, to acquire beginning skills in interviewing, and some general understanding of people's problems.

At the National Social Work Conference in Atlantic City in 1951, an evening seminar was devoted to an exchange of experience among those involved in social work teaching in medical schools. Tentative agreement was reached on sponsorship by the A.A.P.S.W. of the regional conference, with eventual representation from these to the larger interdisciplinary meetings.

Acceptance

The annual report of the Committee on Environmental Medicine was accepted without revision at the Business Meeting, Tuesday, October 30.

Committee on Financial Aid to Medical Education

GEORGE PACKER BERRY, chairman: During the past year the Committee on Financial Aid to Medical Education has concentrated on two lines of endeavor: (1) securing the passage of suitable federal legislation to provide emergency financial assistance to medical education, particularly the passage of S. 337 in the Senate and H.R. 2707 in the House, and (2) working in every way for the success of the National Fund for Medical Education, Inc. Since the prospects for financial assistance from federal sources through the present Congress are now very slim, and since the National Fund, although making progress steadily, is doing so slowly, the committee recommends to the schools that explorations also be pushed in other directions for the solution of their financial problems.

The financial plight of the medical schools continues to be desperate, particularly in the case of the private schools. Increases in the funds to support research through specific grants have had only a minimal effect toward ameliorating the total problem. Indeed, in a number of instances, the schools have been too poor to be able to "afford" accepting increased support for research. Tax-supported schools are somewhat better off in many instances, owing to larger appropriations of state and municipal funds. While the total amount being spent through the medical schools has increased significantly in the last few years, the march of inflation has obliterated the gains, which have been very uneven at best. Thus, the main stem continues to wither while the branches expand.

Federal Aid: S. 337, which had been brought out on the Senate floor with the Pastore amendment incorporated by the Senate Committee on Labor and Public Welfare, was killed on October 4, 1951, the Senate voting down the amendment 42 to 23.

Your chairman withdrew his support of the bill in its amended form, as did the deans of many medical schools, because the amendment so changed the philosophy of the proposed legislation that it became a strong appeal for quantity at the expense of quality. It seemed better to have no bill at all than to have one embodying a dangerous amendment that proposed a seductive stimulus to overexpansion. This point of view is enlaged upon in the documents attached as an appendix (see page 58). These include an explanatory letter prepared by the chairman on October 9, 1951, setting forth in detail what happened to S. 337 in the Senate on October 4, and accompanying copies of telegrams and letters passing between your chairman and Sen. James Murray, chairman of the Senate Committee on Labor and Public Welfare, and Sen. Robert A. Taft.

National Fund for Medical Education: Last spring, after some two years of embryonic life, the National Fund for Medical Education became a reality. With the very substantial help of the American Medical Education Foundation, established earlier this year by the American Medical Association, the national fund was able to announce publicly last May that a total of $1,132,500 had been collected. This sum, in the form of initial Class A grants, was distributed to the 79 medical schools of the country, $15,000 to each four-year school and $7,500 to each two-year school. This is a good beginning for which all the schools' administrators are extremely grateful.

It is noteworthy that the fund's trustees, in awarding these initial grants, stipulated that they were for the unrestricted use of the schools' teaching programs. Small as these grants may be, it also is note-

worthy that, for many of the schools, they will constitute the largest unrestricted sums available for use during the coming year. The unrestricted nature of the grants indicates a true appreciation by the fund's trustees of the dire need of the medical schools and in turn places upon the schools an added responsibility to continue to strive for the maintenance of the highest possible teaching standards and to improve them wherever possible.

While the accomplishments of the national fund to date are modest, the potentialities of the fund for the future are great. It has many original aspects for increasing financial support of medical education in that it brings together many segments of the community in a joint endeavor. One must not fail to realize that it may be an effective instrument for educating the public about medical education and its vital importance for modern society. It is sincerely hoped that the fund will continue to grow and to gain in acceptance by the public generally.

Because Chase Mellen Jr., executive director of the National Fund for Medical Education, will make a separate report at the 62nd Annual Meeting of the Association, further elaboration herewith would be superfluous. Meanwhile, your chairman suggests that it would be in order for the Association to pass an appropriate resolution of thanks to the fund's trustees and also for the schools' administrative officers to unite in their efforts to assist the trustees in the task they have voluntarily accepted to help the schools overcome their pressing financial difficulties.

Resolutions

Upon the motion of Dr. Berry, resolutions expressing appreciation to the National Fund for Medical Education and to the American Medical Education Foundation were unanimously passed as follows:

"I move that the deans of the medical schools, in assembly at French Lick for their 62nd Annual Meeting, unanimously express their sincere appreciation and their enthusiastic thanks to the trustees and officers of the *National Fund for Medical Education* for their devoted and time-consuming efforts, voluntarily assumed on behalf of the deans and their faculties, and for their effective help to the medical schools in these times of crippling financial distress."

"I move that the deans of the medical schools, in assembly at French Lick for their 62nd Annual Meeting, unanimously express their sincere appreciation and their enthusiastic thanks to the trustees and officers of the *American Medical Education Foundation of the American Medical Association* for their substantial support of medical education and for helping to focus national attention on the serious financial predicament of the medical schools."

DR. BERRY: The financial plight of the medical schools is receiving increasing and alarmed attention by the administration of their parent universities. Noteworthy are the reports of the Commission on Financing Higher Education. (The commission is an independent body sponsored by the Association of American Universities and financed by grants from the Rockefeller Foundation and the Carnegie Corporation. It is engaged in a long-range study of the financial problems of American colleges and universities.) In the pamphlet entitled, "The Impact of Inflation Upon Higher Education," published by the commission a year ago, the impact of rising costs and shrinking dollars was lucidly set forth. Last May a second pamphlet entitled, "Financing Medical Education," stressed the national necessity of solving the financial predicament of medical schools. From the point of view of the parent universities, this analysis considered many of the factors currently undermining the security of medical education and suggested a variety of remedies that deserve careful study. In this connection, the anticipated publication within the year of the report of the Survey of Medical Education, with its detailed analysis of the problems involved, is eagerly awaited.

Many schools may be driven to increasing tuition fees. In the face of soaring living costs this expedient promises little, for it will lead rapidly to diminishing returns both in terms of dollars and the breadth of student selection.

Many schools are successfully appealing to their alumni for annual contributions. This source of additional support deserves full exploration.

By an effort to secure adequate reimbursement for overhead in connection with the large annual grants flowing into the schools to support specific research projects, there is hope for substantial relief. This difficult problem deserves careful study; it must not be exploited unfairly nor in a way to jeopardize research activities.

On these and on many similar questions your committee hopes for your suggestions and the opportunity to benefit by free discussion.

Acceptance

The annual report of the Committee on Financial Aid to Medical Education was accepted at the Business Meeting, Tuesday, October 30.

Appreciation

A vote of appreciation was given the Committee on Financial Aid to Medical Education for its efforts in support of Senate Bill 337.

APPENDIX—REPORT OF COMMITTEE ON FINANCIAL AID TO MEDICAL EDUCATION

1. Letter from Dr. Berry to the Deans

October 9, 1951

Dear Doctor:

The present letter summarizes the fate of S. 337 in the Senate on October 4, its current status, and the role I played in "killing" the Pastore amendment.

On October 4, the Senate, by voice (unrecorded) vote, recommitted S. 337, Federal Aid to Medical Education. This means that the bill is being returned to the Senate-Labor and Public Welfare Committee, but recommittal has been suspended by a motion (now pending on the Senate floor; may be considered at any time) to reconsider the recommittal. It seems very unlikely that the bill will pass in 1951; there is only a remote possibility that it will come up again.

Senate discussion of S. 337 on October 4 was complicated by Sen. John O. Pastore's (D., R.I.) amendment to provide $200 per existing medical student and $2,200 for each new student. (The unamended bill had called for $500 and an additional $500.)

I informed the Senate that I would oppose the amended S. 337 because the amendment so changed the philosophy of the bill that it became a strong appeal for quantity at the expense of quality. My reasoning was that it is better to have no bill at all than to have one embodying a dangerous amendment that is really a seductive stimulus to overexpansion.

The Senate killed the Pastore amendment, 42 to 23, with the final vote as follows:

FOR: Benton, Douglas, Green, Hayden, Hill, Humphrey, Hunt, Ives, Kefauver, Kerr, Kilgore, Langer, Lehman, Long, McFarland, McMahon, Monroney, Moody, Morse, Pastore, Robertson, Sparkman and Stennis. *AGAINST:* Bennett, Brewster, Bricker, Butler-Neb., Carlson, Case, Connally, Dirksen, Dworshak, Ecton, Ellender, Ferguson, Flanders, Gillette, Hendrickson, Hoey, Jenner, Johnson-Colo., Johnston-S.C., Knowland, Lodge, Malone, Martin, Maybank, McCarran, McCarthy, McClellan, McKellar, Millikin, Mundt, Nixon, Saltonstall, Schoeppel, Smith-N.J., Smith-N.C., Taft, Thye, Watkins, Welker, Wiley, Williams and Young.

Senators who were most active on the floor in opposing the entire bill were senators Dirksen, Taft, Carlson, Schoeppel, Bricker, Capehart and Johnson of Colorado. Those most active in favor of the bill were senators Pastore, Lehman, Benton, Hill, Hunt, Kerr, Long and Humphrey. It is conceivable that some of those who voted against the amendment might have voted in favor of final passage of the bill if given the opportunity (Bulletin No. 34, October 5, 1951, from the Washington Office of the American Medical Association, Joseph S. Lawrence, director.)

The following analysis of the situation is taken from *Washington Report on the Medical Sciences* (No. 226, October 8, 1951, Gerald G. Gross, editor):

"The setback suffered by S. 337 hinges on Thursday's defeat, by vote of 42 to 23, administered to a committee amendment granting highest federal subsidies to professional schools that increased their enrollments. Proposal of this amendment, described by WRMS two weeks ago (No. 224), was a strategic move designed to capture votes of Southern Democrats who otherwise might have opposed the bill on anti-Ewing, anti-"socialized medicine" grounds. What happened was that the strategy boomeranged, the amendment being defeated and recommittal of the bill being requested immediately afterward by its floor manager, Sen. John O. Pastore (D., R.I.), because he realized that it would be decidedly risky to let the bill itself be brought up for a decisive vote in this charged atmosphere.

"Highlight of Wednesday's debate was Senator Taft's declaration that he now opposes S. 337, which he formerly cosponsored, as well as the proposed amendment to increase incentive payments to medical, dental, nursing and other professional schools covered in this bill. He claimed that many of the medical deans lined up in support of the legislation, including Harvard's, Yale's and Cornell's, had informed him their support would be withdrawn if the amendment were adopted. He voiced anxiety that it would only be an incentive to overcrowding and, referring to the bill proper, permit the government to intrude itself upon selection of students.

"On Thursday, when reconsideration motion by Sen. H. H. Humphrey (D., Minn.) reopened debate after Pastore's move to recommit had been agreed to, spirited verbal exchanges ensued among Taft, Pastore, Humphrey and latter's Minnesota colleague, Thye (R.). Pastore bitterly charged he had been abandoned by fellow members whose floor support he had counted on. Thye joined Taft in denying that the 'abandonment' was based on party differences, to which Pastore replied: 'Mr. Republican (addressing Taft), I am not that naive.' Thye stated he was prepared to vote for S. 337, without the controversial amendment, and similar views were expressed by senators Ralph E. Flanders (R., Vt.) and Willis Smith (D., N.C.). Note: Two additional amendments, intended to be restraining influences, have been proposed, one by Smith and the other by Johnson (D. Colo.). Former eliminates S. 337 language on schools' admission of out-of-state students; latter allocates operating funds to military budget, accenting emergency idea."

I should welcome your comments on this sad situation.

Sincerely yours,

GEORGE PACKER BERRY, M.D.
Dean

2. *Telegram to Dr. Berry*

October 4, 1951

Early this afternoon the Senate of the United States will vote on S. 337. Yesterday Senator Taft announced that he understood that the Association of American Medical Colleges would rather have the bill defeated than passed with the amendment adopted by the Senate's Committe on Labor and Public Welfare. He also said that he would vote against the bill whether or not the amendment was adopted. This is a most important question to this nation. We who legislate for the nation have a right to honest, sincere, truthful advice from those citizens who intimately know the subject before us. We cannot and should not have to expect double-dealing, double-talking, or refusals to answer on the part of such citizens. Therefore, and because I think the deans of our medical schools can be relied on to properly advise their government and because a very prompt answer is essential to the legislative process of your government, will you please reply to this wire immediately.

Representatives of the Association of American Medical Colleges and individual deans, of which you were one, testified to a committee of the Senate that our medical schools were in dire need of financial assistance; that they could not maintain the quality of their instruction without such assistance. They told us that $500 of federal money for each enrolled student would materially aid in solving this "ciritical financial problem." This was the burden of your testimony.

Now keep this next fact in mind. S. 337 with or without—I repeat, with or without any amendment—offers your school some financial assistance in meeting what you testified to be a most serious problem. The unamended bill offers $500 per student currently enrolled. The amended bill would offer, not the $500 you would like but at least $200 for each student currently enrolled. Either offer would obviously help, at least in part and with no strings attached, what you said was a serious financial problem—and, if it is serious, any help is a help.

Now another point to keep in mind before you answer my question, the $200 per student which the amended bill would offer is offered unconditionally. No school would have to take in one single additional student to get some of the financial aid which you told a Senate committee the schools need. If a school wanted to expand by taking in one or two or 10 or 20 additional students with the federal government paying $2200—almost its entire cost for so expanding—it could. The decision, however, is entirely up to the school. If it decided not to, it still gets some of the financial aid which your Association said the schools must have—at least $200 per student and perhaps more if the House of Representatives agrees with you as to the amount the schools both need and should get from federal funds. Now one last point I must ask you to keep in mind before I ask my question.

Some deans have said that the incentive payment offered by the amended bill might lead some schools—never their own, always some other schools—to lower their standards. I would remind you that to prevent any such possibility the bill provides: first, that incentive payments can be made up to but not to exceed a 30 per cent increase in enrollment; second, that federal contributions cannot exceed 50 per cent of any school's total costs; and finally and most important, that not one penny of federal money will go to any school which is not accredited by a recognized accrediting body. You know and

I know and the legislative history of this bill shows that the only recognized accrediting body as regards medical schools is the American Medical Association. This means no school could lower its standards below accepted standards in order to take undue advantage of the incentive payments without the approval of the A.M.A. If it should, your Council on Medical Education need only withdraw accreditation to stop its receipt of any federal funds.

Keeping these points in mind, remembering your testimony to your government as to the critical need of medical schools for funds, and remembering the deans' testimony that our bill is so drawn as to preclude any possibility of federal intervention with your affairs, please answer this question: would you rather have this bill killed than have it passed with the committee amendment? If your answer is Yes, will you please give me your reasons in the light of the points set forth above. The Senate of the United States will vote on this important measure this afternoon. May I ask that as a responsive citizen you reply immediately.

JAMES E. MURRAY, *Chairman,*
Committee on Labor and Public Welfare

3. *Telegram to Senator Murray*

October 4, 1951

Before your telegram arrived I had learned from Washington by telephone that the Senate had killed the Pastore amendment (the compromised Russell-Kerr amendment) to S. 337 early this afternoon, and had then recommitted the bill to committee by voice vote. Of course I am happy nevertheless to answer your question: why did I withdraw my support from S. 337 with the Pastore amendment?

I deeply regret feeling forced to withdraw my support because of the Pastore Amendment. As you know so well, I have worked energetically for months for the passage of S. 337 in its unamended form; i.e., as printed on January 11, 1951. The original S. 337 provided $500 for each medical student currently enrolled and an additional $500 for each medical student enrolled in excess of the average past enrollment. This went a long way toward providing the financial help so much needed by the going enterprise of medical education. It provided also a reasonable inducement for expansion. The Pastore amendment, $200 and an additional $2,000, puts an unreasonable emphasis on expansion while simultaneously jeopardizing the going enterprise.

Two hundred dollars is completely inadequate. A drowning man will grasp at any straw. Hardpressed schools might not be able to resist the eleven-to-one incentive for overexpansion even at the grave risk of reducing the quality of medical instruction. The health and welfare of our citizens rest on the services of well-trained physicians. Only well-trained physicians can give it. The Pastore amendment stresses quantity at the expense of quality. Therefore, I preferred to see S. 337, with the Pastore amendment, killed rather than passed. The need of the medical schools for S. 337 without the Pastore amendment is as desperate as ever. Hence I hope that the bill will be reintroduced promptly without the Pastore amendment.

GEORGE PACKER BERRY, M.D.,
Chairman of the Committee on Financial Aid to Medical Education of the Association of American Medical Colleges.

4. *Letter to Senator Murray*

October 8, 1951

Dear Senator Murray:

The present letter is written to amplify my telegraphic answer (copy enclosed) to your telegram of October 4, and to explain more definitively my objections to the Pastore amendment, the modified Russell-Kerr proposals. Since I had already stated why the Russell-Kerr proposals made the bill unacceptable, your telegram came as a great surprise.

May I say to clear your mind of any possible doubts that I am as strongly in favor of S. 337—without the Pastore amendment—as I was when I testified before your committee. As printed on January 11, 1951, S. 337 is a constructive —indeed, a very necessary—piece of legislation. With the Pastore amendment, S. 337 loses its value, in my opinion, as a force for good in medical education and becomes a dangerous experiment, rooted in a philosophy that the compelling need in medical education today is quantity rather than quality. In fact, S. 337 with the Pastore amendment is an entirely *different* bill from the unamended version, the two bearing only a superficial relationship to each other. The amendment is so seductive that it opens the real possibility that we shall convert struggling medical schools which are fighting to maintain their standards into diploma mills because in this direction would lie presumed immediate financial security.

I think, then, we are clear on this point: I am strongly in favor of the original S. 337. I am strongly opposed to it with the Pastore amendment or any equivalent amendment which might create a situation reminiscent of the days before 1910 when, in many areas of medical education, quality was a secondary consideration in many schools.

The desperate need in medical education today is for "hard money" which can be invested in the teaching program in order that schools can maintain the teaching standards which have soared so high in the last 50 years. There are about 15 per cent too few teachers in the medical schools today due mainly to the inability of the schools to budget for these necessary positions. This is a dangerous situation and if it continues, the health standards of the American people and the defense effort will suffer. But one cannot cure this situation by offering the medical schools large sums of money to expand at a time when they are struggling hard simply to keep their present teaching programs abreast of scientific advances in medicine and to maintain a reasonable student-teacher ratio.

It seems to me that the Pastore amendment has the cart before the horse, or, if I may be permitted to mix this metaphor slightly, the Pastore amendment is equivalent to urging a half-starved horse to run faster. What the half-starved horse (the medical school) needs first is a good meal. Is it not folly to expect the medical schools, already struggling under their present burden, to expand and thereby increase the burden? I realize, of course, that no medical school is forced to take the extra money, but on a basis of $2,200 per new student, the temptation of immediate gain is great and to the extent that such a temptation exists, the teaching program is in jeopardy.

The Pastore amendment, therefore, instead of solving a problem, creates one.

Let me say all this again in another way: this amendment assumes that by increasing the number of medical students, the teaching problem in medical education will be solved. Yet the problem at the moment is finding money for enough teachers to handle the present teaching program and insuring that these teachers are adequately paid for their services. Adding more students will not simplify the matter—even at $2,200 per student—it will only complicate it.

As a matter of fact, there is a fundamental point of confusion in this question that I think we should try to straighten out. It is this: the quality of teaching and the number of students taught are two different matters. The medical school deans have supported S. 337 because it represents an effort to maintain quality and, in some areas, to improve quality. The question of quantity —the number of students to be taught— is quite a different matter. To the best of our financial ability to do so, we are adding students as rapidly as possible to our schools. As you know, far more than money is involved in expansion—training adequate teachers, for example. We do not want, however, the educational structure skewed so badly out of shape that the larger classes will suffer for lack of competent and extensive enough instruction. To do so, would do harm rather than good to the health of the nation.

What we would like to do, then, is make more secure our present educational structure, improving it where possible, and offering the best possible education to as many students as we can afford to admit. Having achieved this, we can continue to expand as the situation permits, but never at the expense of quality. The Pastore amendment offers too little toward quality, too much toward quantity. It is a foolish amendment, poorly thought out, in my opinion, and by no means a "compromise." An amendment as drastic as this does more than compromise: it changes the basic philosophy of the bill.

May I say again that I hope S. 337 will be reintroduced without the Pastore amendment, or an equivalent. I hope you will continue your greatly appreciated efforts to further passage of this bill. I shall continue to give you all the assistance I can in presenting the facts of medical education before the Senate.

Very truly yours,

GEORGE PACKER BERRY, M.D.
Chairman, Committee on Financial Aid to Medical Education,
Association of American Medical Colleges

5. *Letter to Senator Taft*

October 8, 1951

Dear Senator Taft:

The Pastore amendment to S. 337 was so ill-advised, so poorly thought out and so changed the philosophy of the bill in my opinion, that it was far wiser to defeat the measure than to pass it as amended. This is what I told you last week during telephone conversations with Mr. Snead. I am writing the present letter to amplify my statements.

I urged defeat of S. 337 with the Pastore amendment with a great deal of reluctance, for I have fought long and hard for a bill such as S. 337 and the response of senators to my queries was such that I expected the bill to pass.

Lest my withdrawal of support for the amended S. 337 create any confusion, I am writing this letter to inform you that I am still very much in favor of the original, unamended bill. I hope it will be reintroduced and that you will vote for it. I hope also that you and other senators will oppose amendments of a nature that will nullify the constructive features of S. 337 as printed January 11, 1951.

The Pastore amendment was a poor one because it placed the emphasis in the wrong direction. The problem at hand is not primarily one of quantity. True, we need more doctors, but even so the first problem is one of quality. We must maintain our standards, improve them where we can. There are about 15 per cent too few teachers in the medical schools and unless this situation is remedied, America's health and the defense effort will suffer regardless of the number of M.D. degrees awarded each year. The shortage of teachers is brought about by many complicated factors, but one important reason is the inability of the schools to budget for necessary teaching positions. We must correct this condition before we jeopardize the entire medical teaching program. S. 337 was a good bill, aimed at helping us through this problem for a limited period. Eventually we hope to be able to solve this problem without calling on Congress, but at the moment we cannot marshal the necessary funds through private channels.

The Pastore amendment provided $200 per student, which is not nearly enough, and $2,200 for each new student, which is much too much. It is such a seductive offer, such an appeal to quantity, that our educational standards would be in jeopardy. This amendment does not help solve our current problem; rather, it creates a new and dangerous one, opening the possibility that some administrators may foolishly think their salvation lies in expansion. First, we must fortify our present program, making it as financially stable as possible, and then, as circumstances permit, we can expand with the expanding needs of the nation. To expand too rapidly might precipitate a disaster in medical education, returning us to the days before 1910 when standards in schools in many areas were very low.

Another important point: there is a limit to federal funds. To use up such a disproportionally large part of potentially available resources for expansion at the risk of quality would be a serious mistake.

Let me say again, then, that although I opposed S. 337 with the Pastore amendment or any similar amendment which places quantity above quality, I am strongly in favor of S. 337 as it came into shape originally. It is a sound bill and a very necessary bill, in my opinion. I hope that you will support it.

Very truly yours,

GEORGE PACKER BERRY, M.D.
Dean

Acceptance

The annual report of the committee, including the appendix was accepted without revision at the Business Meeting, Tuesday, October 30. A special vote of thanks was given to the committee for the work performed.

Committee on Veterans Administration—Medical School Relationships

R. HUGH WOOD, chairman: At the panel discussion on veterans affairs held at the annual meeting of the Association of American Medical Colleges in October 1950, a resolution was passed requesting that the Association appoint a Committee on Veterans Administration-Medical School Relationships. In December of 1950 announcement was made from the office of the A.A.M.C of the formation of this committee.

Before the committee had its first meeting, a matter of major importance came to its attention when a crisis was precipitated in the Veterans Administration hospital program with the "resignation" on January 14, 1950, of the chief medical director, Dr. Paul B. Magnuson. In order to consider all aspects of the unsatisfactory conditions in the VA policy and program, culminating in Dr. Magnuson's dismissal, the committee wrote to all chairmen of deans committees in the nation, asking for an expression of opinion. Some 50 replies were received. All but one of these letters expressed grave concern for the future of the medical program of the VA which had been established under General Bradley and Dr. Hawley. Because of the prevailing feeling of apprehension, deans of all medical schools affiliated with a Veterans

Administration hospital were invited to consider the matter at a meeting in the Palmer House in Chicago, Sunday, February 11, 1951, during the A.M.A. Congress on Medical Education and Licensure.

The Committee on Veterans Administration-Medical School Relationships was invited to attend a meeting of the Executive Council on February 9, 1951, at which the administrator of veterans affairs, Gen. Carl A. Gray Jr., and Dr. Paul B. Magnuson appeared. The points at issue were of such importance that the Executive Council, in combination with the Committee on VA Relationships, jointly considered the matter during the next 24 hours. The committee report, therefore, is combined with the statement made by the Executive Council of the Association on the date of February 12, 1951, a copy of which is attached hereto.

There were 41 medical schools represented in the meeting at the Palmer House, Sunday, February 11, 1951. All present expressed universal feelings of apprehension and concern for the future welfare of the VA program because of the increasing difficulties with administrative matters bearing directly upon the professional care of patients. Many incidents occurring in different hospitals over a period of two years which adversely affected the medical care of the veteran patient and which made Dr. Magnuson's dismissal even more significant were brought out in this meeting. The group voted unanimously to request the A.A.M.C. to take prompt action to see that sufficient autonomy and authority be given the Department of Medicine and Surgery to insure that the veteran patient would continue to receive the highest quality of medical care.

At the request of Sen. Hubert Humphrey, Dr. Joseph C. Hinsey, Dr. John B. Truslow and Dr. R. Hugh Wood appeared before the Senate Subcommittee of the Committee on Labor and Public Welfare which was investigating the medical program of the Veterans Administration on February 20, 1951. The statement of the Executive Council of February 12 was read by Dr. Hinsey, following which Dr. Truslow and Dr. Wood cited difficulties stemming from the cumbersome organization of the VA and the arbitrary attitude and policy of certain administrators.

At the completion of the hearings of this subcommittee, it made public its report and recommendations on July 11, 1951. This report was quite satisfactory in its general tone and attitude toward the necessary changes in VA organization and policy in order to insure a high quality of medical care. The following five recommendations to be accomplished by and within the VA are significant:

(1) The VA administrator should formally delegate to the chief medical director such primary authority as may be necessary to insure his effective control over all policy affecting the care and treatment of patients and over the management and operation of the hospital system, and this delegation of authority should be clearly and unequivocably set forth.

(2) No one shall be appointed manager of a VA hospital without the prior approval of the chief medical director.

(3) All special services personnel and activities in VA hospitals must be under direct control of hospital managers and operate only in accordance with policies approved by the Department of Medicine and Surgery; furthermore, consideration should be given to abolishing the office of assistant administrator for special services, not now under the control of the medical director.

(4) Budgetary control procedures should be revised, with a view to making the hospital manager responsible for a single budget.

(5) Personnel ceiling procedures should be revised to give the chief medical director more flexibility in the allocation of personnel to hospitals.

In addition there were three recommendations for changes in the legislation pertaining to the VA, to be enacted by Congress. They are:

(1) Public Law 293 (79th Congress) should be amended so as to leave no doubt whatever that the Congress intends the chief medical director to be the principal medical authority of the agency with primary authority to control, manage and operate its medical and hospital program.

(2) The law (38 U.S.C. 15) should be amended to provide that the chief medical director be appointed by the President with Senate confirmation.

(3) Functions of the special medical advisory group to VA (established by P.L. 293, 79th Congress) should be realigned to provide for (a) changing the name of the group to the Advisory Commission on Veterans' Medical Care, (b) appointment of commission members by the President, (c) representation on the commission of the public, veterans and

"eminent authorities in the respective health professions," including members of the deans' committees, (d) continuing review by the commission of VA's medical and hospital program, with a report at least annually to the administrator and the chief medical director, and (e) regular reports to Congress by the administrator on the commission's recommendations and his action with respect to them.

This report of the Senate subcommittee further stated that these recommendations were read in the presence of the administrator and the chief medical director of the VA, and that they agreed with the principles and implications of these recommendations.

The chairman of the committee had the opportunity to ask Admiral Boone on October 5, "What has the VA done to carry out the five recommendations made by the Subcommittee of the Senate Labor and Welfare Committee?" Admiral Boone replied that the administrator had deemed it wise to wait until the report of the management survey now in progress by Booz, Allen and Hamilton had been complete. In quoting General Gray, Admiral Boone expressed the feeling that if changes in reorganization were made now, it might result in confusion because of additional changes or even conflicting changes that might be recommended by this management survey.

Dr. Robert S. McCleery of Nashville, Tenn., for himself and representing a committee of citizens in Nashville, has visited many of the medical schools and all the members of the Executive Council of the Association of American Medical Colleges. He is concerned, as are many other citizens, with the problem of abuse of the privilege of nonservice-connected veteran patient, who may now be admitted to the VA hospitals on his own sworn statement that "in his opinion" he is unable to pay for the necessary services. Upon the request of the chairman of the Executive Council, Dr. Wood and Dr. McCleery visited Admiral Boone on October 5, 1951.

A conference with Admiral Boone and Judge E. E. Odom, the solicitor of the VA, was held and all points at issue were fully discussed. It was pointed out that the VA operates under what is known as *permissive* legislation. This is in contradistinction to the legislation under which the armed services and other federal agencies operate and means that the VA may do nothing except what is *expressly permitted* by law, whereas the armed services may do anything except those things which are *expressly prohibited* by law. Therefore, the Veterans Administration is not able to enforce penalties provided for fraud, nor are they able to investigate the financial status of VA patients. However, the managers of the hospitals are permitted to report obvious instances of fraud, and directives from central office have been issued to this effect.

The solicitor was asked, "Are instances of fraud reported to central office, and if so, what has been done about it?" Judge Odom replied that in past years, following the legislation passed in 1935, instances of fraud were reported regularly by the hospitals to central office. If the case seemed clearcut and the evidence sufficient, these cases were referred to the Department of Justice for prosecution. Many cases were brought to trial by the Department of Justice, but not one conviction of a veteran patient has ever been secured. The Department of Justice, therefore, has stopped trial of cases it could not win; central office has ceased to refer them to the department; and finally the managers have ceased to report them to the central office. In this way, enforcement of the law has broken down all along the line.

A full statement of public law governing the operation of the Veterans Administration and VA directives pertaining to policy and procedure dealing with the nonservice-connected VA patient who is able to pay for medical care was promised the chairman of the committee but did not arrive in time for inclusion with this report.

Dr. Robert McCleery posed the following questions which he hoped Admiral Boone would be able to answer at this meeting of the Association in French Lick. They are: (1) Where in the Public Law governing the operation of the VA is the prohibition against later investigation of the sworn statement on Form P-10, which the veteran signs upon admission to a VA hospital, and by which he declares that he is unable to pay for the medical care he needs? (2) Where in the Public Law may be found the authority for accepting a veteran with a nonservice-connected disease or injury for treatment in a VA hospital, who at the same time possesses a private insurance hospital policy which would pay his hospital and physician fees? These questions also were not answered in time for inclusion this report. It is hoped that Ad-

miral Boone will be able to throw some light on these matters when he appears before the Executive Council.

The only further matter which has come to the attention of this committee has been a statement directed to Dr. Hinsey by Dr. Robert B. Aird, chairman of the combined dean's committees of the Veterans Administration Hospital, San Francisco, Calif. He addressed the following complaints to Dr. Hinsey, who in turn referred them to the chairman of the committee. In his communication, Dr. Aird called attention to the fact that sweeping changes in budget, policy and procedure have been made by central office of the VA without prior consultation with the deans committee and that the position of the deans committees of his institutions was made untenable by these changes. Correspondence is included, dating from April 12, 1950, in which these matters were called to the attention of the administrator and the chief medical director. The request was made that these matters should be considered at the next meeting of the A.A.M.C., the feeling being that these difficulties are of the same nature as those experienced by other deans committees and therefore cause for concerted action by the A.A.M.C.

The Committee on Veterans Administration-Medical School Relationships recommends that the A.A.M.C. officially consider the items set forth in this report and that specific action be taken on the following points:

(1) The VA should be requested to assure the medical schools that it is prepared to put into effect the five recommendations of the Senate Subcommittee.

(2) The A.A.M.C. must be assured by the VA that it is in agreement with the recommendations of the Senate Subcommittee as quoted in this report.

(3) This committee recommends that consideration be given to the desirability of amending the federal law in such a way that the relationships of medical schools to the VA be so organized as to take the form of a contract.

(4) The abuse of the privileges of hospitalization by veteran patients with nonservice-connected disabilities who are able to pay for the cost of adequate medical care, is reported to be widespread. Accordingly, the committee recommends:

(a) That each medical school, through its dean's committee, ascertain the extent to which such a practice might endanger the present high quality of medical service being given in its affiliated Veterans Administration hospital or hospitals.

(b) That each medical school take such steps as may be seen to be appropriate to protect the present programs of medical education and care; and

(c) That the Association of American Medical Colleges ask the Veterans Administration for a full statement of all laws, directives and policies pertaining to the admission of veteran patients in this category.

Acceptance

The annual report of the committee was accepted at the Business Meeting, Tuesday, October 30, after the final paragraphs were revised to read as above.

Committee on Foreign Students

FRANCIS SCOTT SMYTH, chairman: Because of the ever-increasing number of requests from foreign doctors for further training in the United States, the Committee on Foreign Graduate Students was formulated to handle this activity. The committee has been functioning under the chairmanship of Dr. Francis Scott Smyth since December 1950. An interim report of committee activity was given in February 1951. The committee has now reached the point of being an important distributing instrument of the Fulbright and E.C.A. programs through the State Department's Committee of Exchange of Persons and/or its various subsidiary agencies.

The Exchange Program: To briefly review: on August 1, 1946, Congress enacted a bill which has come to be known as the Fulbright Act, which authorized the Secretary of State to use foreign currencies which were not convertible into dollars to finance Americans studying abroad and to help bring foreign students into the United States. The foreign currencies came from the sale of surplus war materials left in foreign countries at the conclusion of World War II, and were scattered throughout Europe, Asia and the Near East. With the enactment of the legislation by the Congress came institution of the program for the exchange of students, which met with immediate favorable reaction among all the people of the free world.

This committee is not concerned with Americans who go abroad to study. Our work confines itself solely to those foreign graduate doctors who come here for further training in order to return to

their native lands to teach. It has taken time for students to learn that since a grant is made in their own currencies instead of American dollars, it can be used only to pay their way to American shores. To cover their maintenance while here they must have either a scholarship from a university, private help or another U. S. government dollar grant (made available under the Smith-Mundt Act).

Figures up to June 30 of this year (quoted by J. William Fulbright in New York *Times* article, August 5, 1951) indicate the equivalent of approximately $11,500,000 in foreign currencies, not repayable in dollars, has been paid by foreign countries for benefits to 7,393 Fulbright grantees. Of these 3,181 were Americans who had gone abroad to study, teach, lecture or conduct research, while 3,234 citizens of other countries have received awards for similar studying in American institutions in foreign countries.

In addition to Fulbright scholars, we are also now handling a constantly increasing number of participants under E.C.A. sponsorship.

Committee Share in This Exchange: The liberal arts are favored by Americans studying abroad, while their counterparts from other lands show a preference for medicine and engineering which will provide them with skills and techniques urgently needed in their countries.

Our own committee has worked in close cooperation with the Conference Board of Associated Research Councils of the Committee on International Exchange of Persons and with the Institute of International Education, as well as various other agencies of the government (Public Health, Federal Security Agency, E.C.A.) through their individual programs under which visitors have come for extended visits.

It is worthy of mention that once a doctor arrives for a period of training, he remains within the division under the direction of his chief for the stipulated period, while a visitor—whether for a long or short period—requires facilities, introductions and much detailed planning to achieve the greatest results from his stay.

Out of a total of 255 applications submitted through the governmental agencies, the A.A.M.C. schools placed 168 doctors (our own schools having placed 25 of these).

The office of the committee chairman handled a total of 80 candidates, either as visitors or grantees, representing 29 different countries. Whatever the category, the problems placed before us were, for the most part, those requiring long range consideration. Brief examples are:

Books: The shipment of medical books and literature to the Philippines and the Orient, to supplement depleted libraries, has been most effectively handled by the Army transport through the able help of Mrs. Carter Collins of the Army Wives' Association. With the signing of the peace treaty with Japan, however, we are trying to ascertain how far this help will extend and continue in these official channels, and without cost to the Association of American Medical Colleges.

Problems: (1) Understaffing in Asiatic Medical Colleges: This is a problem which has come to us through many channels: whether medical schools—like that of Taegu in Korea—should recall the men who have been training in the United States in order to meet the dire need for practitioners in those countries or permit these men to remain for completion of the work which they had set out to do. The Presbyterian Board of Foreign Missions, and especially Harould Loucks of the China Medical Board have offered much in the way of constructive help and suggestions in this field.

Visitors from Korea, Burma and Indonesia, correspondence from India, as well as the current situation all point to the grave problem in this perimeter of the globe as to the type of training which should be instituted in the medical schools for the best long range result within these lands. Discussions and correspondence with agencies and boards produce conflicting theories. Delegations of specialists for a limited period are urged by some as being the answer to a quick solution for producing native teachers; others favor a combination of delegations for an extended period of time to teach the basic sciences and to set up the most efficient working standards to meet the needs of the particular land for which doctors are being trained. This program is to be supplemented, in any case, by faculty or potential faculty coming to the United States for postgraduate training. Consideration of these factors is important and necessary, and thought should be given it by the Committee on Foreign Graduate Students.

(2) Ultimate Aims for Health and Welfare of Populations: In areas of dense populations with few schools of medicine and proportionately few doctors, this aim cannot be achieved by education of only

a select number of doctors. Something more is required to meet the general health and welfare needs of these people. Mass education of the people is desirable and can be more rapidly accomplished if less orthodox techniques (such as those used by Jimmy Yen in China for language) are applied as fits the native situation, rather than those techniques fixed and orthodox for the occidental areas.

Historically, the physician is both a teacher and therapist. The healing art for the individual patient and the dispensing of drugs precedes the realization that prevention of disease, sanitation, and nutrition are ultimately the goal of the health sciences. It would thus seem desirable in regard to the role of medical education in certain areas to emphasize the participation of the faculties and physicians in programs by which the education in prevention, sanitation and nutrition can be more quickly acquired by the population. While in our country this is the role of the public health professionals, it would seem unlikely that the ordinary school of public health is the entire answer. Rather, it suggests the need of widespread participation of natives in short training schools, not so much as therapists but as preventive health agents. Without specialized education requirements, elaborate laboratories or great technical facility selected young people could be trained in the rudiments of midwifery, contagion prevention, sanitation and nutrition in six to 12-week periods. It would be of benefit to all to hear Dr. Leo Eloesser discuss his active experience in this field in his work with the World Health Organization.

Future Activity of the Committee: With the expanding participation of the committee in the international picture, there now arises the responsibility of considering the next logical step which may arise in our dealings with the State Department through its authorized agencies. With large appropriations to be made available for technical and medical education of the countries coming under the Economic Cooperation Administration's program in designated countries, we are bound to be faced with the acceptance of the challenge and determining the form which our assistance is to take.

Recent trends in policy have focused the attention of the committee chairman to the E.C.A. program in Southeast Asia, with special consideration of Indonesia. The problem in these countries is not primarily lack of money to pay for needed imports but, rather, the lack of technical equipment and skill to carry forward the necessary programs of reconstruction, rehabilitation and development. Medical schools in these countries are faced suddenly with the problem of educating the greatest number of doctors in the shortest span of time. The only possible source of additional faculty for training their future doctors would be provided by the consideration of the A.A.M.C., and the extent to which they can assist these countries in meeting this demand. This is, of course, in addition to permitting a select few to come to the United States for further training and again returning to their native land to teach.

It is the view of the chairman of this committee that the Association of American Medical Colleges, through its Committee on Foreign Graduate Students, has honestly and intelligently cooperated not only with the State Department of the United States in its primary aim of aiding international understanding, but also to the men who have sought and come to our land to further the basic aims of extending medical education.

Acceptance

The annual report of the Committee on Foreign Students was accepted without revision at the Business Meeting, Tuesday, October 30.

Additional Reports

As a part of the report of the Committee on Foreign Students, the following reports were made by Dr. Howard Kline of the U. S. Public Health Service, and by Dr. Robert Moore of Washington University:

DR. KLINE: As part of the overall program of both the Department of State and of ECA, to assist in the technical development and the economic development of certain underdeveloped countries, the Public Health Service has urged the Department of State and ECA to invest part of its effort in moves to improve both the health and the medical facilities to meet the medical needs of the people of these underdeveloped countries. We wish to assist them to meet their needs quantitatively and work for the improvement of the medical personnel being trained in their several countries. In the matter of quality, we urged both ECA and the Department of State, and so far only ECA has gone its way to do this. The Department of State may well follow. We have urged them to turn to the medical schools, student nursing schools, schools of public health, and other re-

lated institutions, and appeal to them and make available appropriate finances to send abroad visiting United States professors to teach in their institutions.

We may ask these professors to specify the limited amount of additional supplies and equipment which will be necessary to substantially improve their teaching, and to receive in this country and train designated nationals, particularly teachers from their training institutions to be received here for further training. There are specific affiliations at this time between Washington University Medical School at St. Louis and Chulakankarana University in Bangkok in Thailand. Preliminary discussions are going on and have been going on, and I understand negotiations are in various stages with the medical schools of Columbia University, University of California, University of Pennsylvania and Johns Hopkins involving potential relationships with the Medical School of Formosa, the University of Indonesia Medical, the Medical School of Rangoon in Rangoon, Burma, and the University of the Philippines Faculty of Medicine.

I would like to take this occasion on behalf of the Public Health Service and other government agencies and private foundations as well to pay special tribute to the splendid and understanding manner in which the members of this Association have received and guided numerous and bewildered foreign fellows who have come to your institutions seeking the higher training which we are so eminently able to provide in this country.

DR. MOORE: At the last meeting of the Association, you will recall Dr. Malmberg presented this matter which Dr. Kline has discussed. For reasons which I need not give you now in detail but will be glad to tell you if there is any reason for it, the relationship between Washington University School of Medicine and the medical schools in Bangkok, Thailand, seemed a natural one because of past events. Therefore, early in November, we offered to negotiate with the Economic Cooperation Administration looking toward a contact. After four months of negotiations, one month of seriousness of principles, and three months of haggling over details which seemed to us important in an academic venture with a comptroller and lawyer and travel expert who had no pervious experience with universities and academic matters, we signed a contract with ECA.

The essential facts of this contract are, of course, that it runs for a two-year period, that we undertake to assist in the development of medical and nursing education in the two medical schools affiliated with the University of Thailand, the Serrot and the Chulakankarana Medical School. We do not undertake any responsibility for medical service in Thailand. This is a program of education and not of service. It is looking toward medical service in the future, not medical improvement. That contract calls for a grant of funds from Washington University along the general lines of other contracts with universities and government. Washington University handles the funds for two general purposes: first, a small amount for administrative expenses in the United States to carry on this program; second, to pay the salaries of the members of our faculty who go to Thailand. Those salaries are paid in dollars. We accept no administrative responsibility for the medical schools in Thailand. We are there to assist and help, and not to run the medical schools. There is no sense of imperialism in our concept or in our contract.

We agree to have not less than six faculty members in residence in Bangkok during the year. We agreed to take whatever number can be reasonably accommodated in St. Louis from their faculty. The selection of those men who come to St. Louis is in the hands of the Ministry of Medical Education of the Government of Thailand with our approval of the candidate and ECA's approval after he is selected by them.

We are not taking men and training them to be physicians. We are taking them to train them as future professors in those medical schools. Again the emphasis is on education and not the medical service.

At the moment, we have 14 people from Thailand in St. Louis and at the first of the year we will have 20. That is all we can possibly take and distribute them between the various departments of the medical school.

At the same time, ECA undertook to send equipment to Thailand which would give the medical school the equipment it needed to do a good job. That equipment landed in Thailand in September of this year. I am sure you are interested in the financial remuneration of the men who go to Thailand. We have no responsibility for the Thai people who come to the United States. That is a problem for the Thai government. We are responsible only for the salaries of our people who go to Thailand. Those men draw their American salary plus 25 per cent for overseas

duty. They are given a living allowance of between $1000 and $1500 a year in addition. If they stay for one year, their entire expense and that of one dependent to and from Bangkok, which is around the world—the air fare is within 50 cents in each direction—is paid for them, and if they stay 12 months, they get one month's vacation with full pay which they can use wandering back to the United States.

We sent out nine people including a bio-chemist, pathologist, pediatrician, surgeon, operating nurse, hematologist and pathology technician. Seven were from our own school and two we got from other schools by those individuals getting sabbaticals from their schools. Two were professors, three assistant professors, three were instructors and one was a technician. Seven of them were to remain for one year and two were to remain for three months or less.

The advantages that we see are first, to the individual there is a professional experience which is tremendous. In pathology, the individual will gain professional scientific experience he could never get any other place under any other circumstances.

We are pleased with the program. We are pleased that the administrator, the assistant dean of the school, went out and stayed two months while the thing got started. He was the only American medical man who has ever been editorialized in the Bangkok newspapers when he left after a stay of two months.

We need some changes in our contract. We propose to take those up with ECA next month. These changes are concerned largely with administrative help in Bangkok with some sort of health insurance for the people who go out.

Now, something about these Thai people who come to St. Louis. When we bring scientific people to the United States, we give them a superb scientific education, but there is something else we are after in contracts of this sort, and that is to sell the democratic way of life, and while those people are in this country, we should take advantage of that and sell them the Western world. That can't be done in the laboratory. It has to be done outside in their relations with the community.

Finally, the reason we are in it and the advantage we see in it: we believe that any group of people who have good health and have food in their stomach will not seek the new way of life, and we want to keep the people of southwest Asia from seeking a new way of life right now.

Committee on Internships and Residencies

JOHN B. YOUMANS, chairman: The work of the Committee on Internships and Residencies during the past year was concerned principally with (1) the operation of the Cooperative Plan for the Appointment of Interns, and (2) with the development of changes in that plan.

For the internship year 1951-52 certain changes were again made in the plan compared with the previous year. These changes consisted, in part, of those recommended following a study of the plan at a conference of the various interested agencies in Chicago on September 13, 1950. Briefly, these provided for the simultaneous filing of telegrams offering appointments after 9 A.M., E.S.T., on the second Tuesday in February 1951, and the release or delivery of the telegrams at, but not before 3 P.M., E.S.T., of the same date. In addition they included for the *following year* (intern year 1952-53) the provision that, "Hospitals and/or students shall not follow telegrams with telephone calls until after 9 A.M., E.S.T., (the following day) except for acceptance of an appointment by a student."

Paragraph 2 of the then existing plan was changed to read as follows:

"Application should be made in duplicate; the original to be forwarded to the dean of the applicant's medical school for transmission, together with credentials to the hospital or hospitals by the applicant as soon as he or she has filed the original with the dean any time prior to December 19 (1950)."

It was also agreed that:

"1. Deans will be advised to have students furnish telegraph office with address and phone numbers where they can be reached February 21.

"2. It will be suggested to the deans that they have students concerned meet in some central place at the proper time on February 21.

"3. That a conference will be held with the Western Union officials at national level but deans are advised to arrange with Western Union at local level also.

"4. That a statement be made to the effect that the plan applies only to graduates of the current year."

At the meeting of the A.A.M.C. at Lake Placid these recommendations were adopted with, however, certain modifications. The provision that "hospitals or students shall not follow telegrams of offers of appointment with telephone calls until after 9 A.M., E.S.T., (8 A.M., C.S.T.;

7 A.M., M.S.T.; 6 A.M., P.S.T.) February 21, except for acceptance of an appointment by a student," recommended for the intern year 1952-53 was made effective for the current intern year (1951-52).

The recommendation that machine matching be used on a voluntary and trial basis was also approved.

These changes were announced and reported to the medical schools, to the hospital associations and hospitals, and to other interested agencies and persons by means of letters to the deans, notices in the Journal of MEDICAL EDUCATION, the Journal of the American Hospital Association and by many individual letters. Unfortunately the American Hospital Association failed to approve the part of the plan concerning the use of the telephone, and this was communicated by mimeograph letter to all deans on February 1, 1951, with the information that the Committee on Internships and Residencies had carefully considered this situation and had decided that it was inadvisable for the Association to attempt to enforce this provision of the plan. Such actions as they might wish to take were left up to the individual deans. Suggestions were given as to procedures which were to be followed locally.

As provided by the recommendations of the committee, approved by the Association, arrangements were made in advance with national representatives of Western Union, and in this the offices of the American Hospital Association were very helpful. Instructions were issued to local Western Union offices by the company and copies were sent to the deans, together with a copy of the statement sent to hospitals by the A.H.A., as a basis for perfecting local arrangements.

A temporary committee to operate the machine matching, with representatives from the various associations concerned, was appointed by the chairman of the Committee on Internships and Residencies, as follows: Dr. Edwin L. Crosby, American Hospital Association; Dr. Edward H. Leveroos, American Medical Association Council on Medical Education and Hospitals; Rev. Joseph A. George, American Protestant Hospital Association; Dr. Francis J. Mullin, Association of American Medical Colleges; Msgr. John Barrett, Catholic Hospital Association of United States and Canada; Col. Richard B. Jones, United States Air Force; Col. James G. Simmons Jr., United States Army; Capt. R. H. Fletcher, United States Navy; Dr. Kenneth W. Chapman, Federal Security Agency, U.S.P.H.S.; Dr. James T. Smith, Veterans Administration.

Dr. Edwin L. Crosby, Dr. Edward H. Leveroos and Dr. F. J. Mullin were elected as the Executive Committee, and John M. Stalnaker designated as director of operations. The actual operation was performed at the office of the A.A.M.C. with facilities provided there. Costs were paid by the Association by means of a special grant. Instructions were sent to all medical schools and hospitals concerned and on April 13, 1951, all hospitals offering internships were notified that the result of the trial run of machine matching was being studied and would be reported later.

In actual operation the plan proceeded more smoothly than in previous years and on the whole was very satisfactory. In part this was a result of greater preparation and familiarity with the plan and to a considerable extent, I believe, to the changes in the plan. On the other hand, there was a considerable number of complaints and objections to unfair practices. Paradoxically, this is believed to have been largely the result of more general and more faithful participation in, and compliance with, the plan. This focused attention to a greater degree on the nonconformists and on those hospitals which participated but failed to observe the regulations. However, the operation of the plan emphasized and demonstrated more strikingly than ever the problems and difficulties caused by the great disparity between the number of approved internships and the number of graduating students, and called attention to the lengths to which some hospitals will go to secure interns. No complaints were made from students or medical schools. Communications from some hospitals indicated a lack of knowledge of the nature of the plan (despite a very considerable amount of publicity and information). The general fairness of the plan seems reflected in the failure of a number of teaching and university hospitals to secure as many interns as they wished.

The machine matching, which was operated on a trial basis as approved by the Association at its meeting in October 1950, was generally very successful despite its "trial nature." Compliance and cooperation were very good and the results demonstrated clearly its value and practicality. A full report has been made to all members of the Association and to the others concerned and will not be repeated here. Suffice to say the trial run justified

the adoption of the procedure on an official and permanent basis as will be discussed below.

The success of the plan and, at the same time, the problems and difficulties disclosed by its operation, the result primarily of the great disparity between approved internships places and the number of graduates, served to direct attention more insistently than ever to the problems of internships appointments.

The committee was fully, even painfully, aware of the problems and had announced its intention to continue its study of them. To this end an ad hoc subcommittee was appointed and met in Chicago on May 23, 1951. As reported to the full Committee on Internships and Residencies by letter dated June 8, the results of the deliberations of the committee were as follows:

It was apparent that we were faced with several alternatives. (1) We could attempt to secure the cooperation of the American Medical Association's Council on Medical Education and Hospitals in having them reclassify internships, reducing the number, or joining us in doing so. (2) We could inspect and classify them ourselves. (3) We could attempt to secure better cooperation with the hospital associations in improving, strengthening and operating the present plan. (4) Finally, we could give up the whole idea.

Both of the first and second possibilities seemed out of the question at the present. We were unwilling to adopt the last course, although it was felt that unless some move was made to strengthen the present plan and put some penalties in it, the plan would die. We had heard from Dr. Mullin that the third choice might be possible and practical, and that both the council and the American Hospital Association were somewhat disposed to cooperate in making the present plan more effective. It was therefore decided to await the report and recommendations regarding future plans and procedures of the temporary subcommittee appointed to operate the trial run of machine matching, which was to meet in Chicago on May 23, 1951.

These were the result of long thought and careful deliberation by the representatives of the various associations and agencies vitally concerned with this problem. Because of the complex and exceedingly difficult nature of the problem the recommendations represented certain compromises but were believed to be a very distinct advance and a sound practical working solution.

In the meantime, at the meeting of the American Medical Association in Atlantic City in June 1951, and while the temporary committee on machine matching was deliberating the problem, the Council on Medical Education and Hospitals of the A.M.A. acted to set up a specified number of internships for each hospital accredited or approved for intern training. This action was reported to the members of the Committee on Internships and Residencies by letter from me on July 7, again on August 2. In reporting on the first meeting of the National Interassociation Committee on Internships, further comment was made on the action of the council of the A.M.A. in reducing the number of approved internships. This action was later rescinded as announced by the council.

As indicated above, the ad hoc National Interassociation Committee, after a study of the results of the trial of the machine matching procedure, arrived at certain conclusions and made certain recommendations. These were as follows and were reported to the Committee on Internships and Residencies as well as to other interested agencies and persons:

1. That a permanent committee, to be known as the National Interassociation Committee on Internships, be established with power to act on procedural matters relative to internship appointment. The committee to be responsible to the constituent bodies of the American Hospital Association, American Medical Association Council on Medical Education and Hospitals and the Association of American Medical Colleges for approval of policy matters. The committee to be composed of the following 11 voting members:

One member designated by the American Catholic Hospital Association; two members designated by the American Hospital Association; three members designated by the American Medical Association Council on Medical Education and Hospitals; one member designated by the American Protestant Hospital Association; three members designated by the Association of American Medical Colleges; one member chosen by and from the five liaison members, representing the Air Force, Army, Navy, Public Health Service and Veterans Administration); one non-rating liaison member to be designated by each of following government services concerned with internships: Air Force, Army, Navy, Public Health Service, Veterans Administration.

When a student organization is representative of a majority of the senior medi-

cal students, consideration should be given to inviting it to designate a representative for membership on the committee.

2. That the administrative responsibility for the operations of the appointment procedures be carried out by the Association of American Medical Colleges under regulations set by the National Interassociation Committee on Internships.

3. That for the appointment of interns to start their internships in July 1952, the matching plan, as conducted this year, be followed as the official method.

4. That whereas the full cooperation of students, hospitals and medical schools is essential for the successful operation of proposed intern appointment plan, the following steps be taken to assure effective participation:

(a) All constituent organizations will adopt the plan officially and actively support it.

(b) A separate list of hospitals participating in the plan will be published with an indication that the plan is sponsored and supported by the constituent organizations. The A.M.A. council will be requested to publish, at the committee's expense, a directory of participating hospitals excerpted from its list of approved hospitals, containing the necessary information for the operation of the plan.

(c) Students and hospitals will be required to sign a contractual obligation to abide by the results of the plan.

(d) The deans of medical schools will be asked to use every effort to have their students comply fully with the plan and to advise their students to apply only to participating hospitals.

(e) Appropriate disciplinary action will be taken by the committee against students and hospitals which agree to participate, but which do not conform to the regulations.

(f) The committee as a whole will act as a review board in the case of complaints regarding conformity. If complaints involve a government service, the liaison member of that service will be voting member of the reviewing board.

5. That in order to proceed with the plan this year, ratification of the proposals and the designation of representatives for committee membership by the boards or councils of the constituent groups should be obtained in time for the new committee to meet by July 1, 1951.

6. That the present National Interassociation Committee serve until the new committee has been formed.

7. That the plan be financed by a charge of $2.50 to each participating student, and a charge of $2.50 to each hospital for each internship filled through the plan. The expenditure of the funds so collected will be under the control of the National Interassociation Committee on Internships.

The report and the above recommendations were presented to the Executive Council of the Association at its meeting in Chicago, by the chairman of the Committee on Internships and Residencies, and was approved. They were similarly presented to the executive bodies of the other associations which also gave approval. Subsequently, this approval was ratified by the individual components of the various associations, as recently reported to the schools and hospitals. Following this approval, the temporary National Interassociation Committee met in Chicago on Friday, July 27, dissolved, and reorganized itself into a permanent National Interassociation Committee on Internships. A statement of the organization, rules of procedure, officers, etc., is attached. The representatives of the Association of American Medical Colleges on the committee are Dr. J. F. Mullin, who is chairman, John Stalnaker and your chairman. The Association of American Medical Colleges headquarters is designated as the operating agency and Mr. Stalnaker is director of operations.

The success of the cooperative plan for 1951-52 of machine matching and establishment of the National Interassociation on Internships has not obscured other problems of the internship, several of which are basic and very important. A number of members have indicated to the chairman and to the committee their concern with these problems and the need to study and solve them. The committee regrets that it has not, so far, been able to act on the resolution of Panel J of the Round Table held at the meeting in Lake Placid ("Specific Internship Requirements for Licensure—Yes or No"), which was referred to it by the Executive Council. The committee is aware of these problems and the need to investigate them. In this connection it may be noted that the Council on Medical Education and Hospitals of the American Medical Association has organized an Advisory Committee on Internships of which your chairman is a member. The establishment of the National Interassociation Committee should relieve your Committee on Internships and Residencies of the details of that activity and free them for a study of other important internship problems.

Acceptance

The annual report of the Committee on Internships and Residencies was accepted without revision at the Business Meeting, Tuesday, October 30.

Planning Committee for National Emergency

STOCKTON KIMBALL, chairman: The Planning Committee for National Emergency has held no independent meetings, but has worked in conjunction with the Council on Medical Education and Hospitals of the American Medical Association through the Joint Committee on Medical Education in Time of National Emergency which represents both associations.

The actions of the joint committee have included the following:

1. Completion and publication in November 1950 in the journals of both associations of the Statement of the Joint Committee on Medical Education in Time of National Emergency. Copies of this statement were sent to the Rusk Committee, National Resources Planning Board and each of the medical schools.

2. A questionnaire study of the possibilities of expanding medical schools' enrollment was made with the cooperation of all of the medical schools. The results indicated that there has been a high degree of expansion in enrollment since the end of World War II, and any further degree of expansion in any considerable numbers would involve the need of securing funds for expanded faculties and for medical school and hospital construction.

3. Compilation in January 1951 by a subcommittee consisting of Arthur Bachmeyer, Harold Diehl, Edward Leveroos, Victor Johnson, chairman, of suggestions concerning policies for faculty, resident and graduate student deferment. These suggestions were brought by Dr. Diehl to the Rusk Committee and were later incorporated in Information Bulletins #4 and #5 released by the National Advisory Committee of Selective Service. These bulletins made provision for the possibility that occasional members of the basic science faculties who were in a one or two priority might be recommended for a 2A occupational classification on the basis of essentiality pending search for replacement. Likewise, occasional residents in rare categories in low priorities might be recommended for one or two years of residency training.

4. Members of the joint committee appeared at a hearing on January 30, 1951, before the Subcommittee of the Senate Armed Service Committee. A statement made at that time was circulated to the schools.

5. Compilation by a Subcommittee on Curriculum of a series of suggestions for supplementing the medical curriculum in time of national emergency. The subcommittee consisted of Gaylord W. Anderson, G. M. Dack, Roy R. Grinker, Roger A. Harvey, Andrew C. Ivy, H. Worley Kendell, Franklin P. McLean, John P. Marbarger, Charles B. Puestow, Stanley W. Olson, chairman. Consultants from the government services cooperated in the preparation of this report. The report was adopted at the meeting of the joint committee in February 1951, printed in the *Journal of the American Medical Association*, and 25 copies were sent to each medical school for their guidance in incorporating the material into their existing courses or for providing any new instruction that seems indicated.

6. Consideration was given to the report presented on February 12, 1951, before the Congress on Medical Education and Licensure, by Dr. Howard Rusk, entitled, "Medicine, Mobilization and Manpower." This was followed by a hearing held by the joint committee on March 8, 1951, with the Rusk Committee concerning this report. At this meeting the conclusions and the basis for the conclusions were argued.

7. Members of the joint committee participated in a hearing on August 17, 1951, concerning universal military training and its impact on medical education. This hearing was held before the National Security Training Commission which is preparing a report due to be released by the end of October 1951.

8. A meeting of the joint committee was held at French Lick October 27, 1951.

Acceptance

The annual report of the Planning Committee for National Emergency was accepted without revision at the Business Meeting, Tuesday, October 30.

Committee on Postdoctoral Education

JOHN TRUSLOW, chairman: The committee on Postdoctoral Education was appointed by letter from the Association office in February 1951. However, except for two interchanges of letters during the past seven months no full committee meeting has occurred until this week.

Therefore no report was prepared in advance of the Association meeting.

The most productive session took place in the presence of a number of members of the Association who assembled for the purpose of discussion of a report. This report, on general principles and general scope of the committee's interests, therefore results largely from this assembly.

Four general principles appeared to find the group in essential agreement:

1. The primary concern of the committee at present shall be the continuous education of the physician, including those areas closely related to that type of training generally understood in the term "graduate education."

2. A fundamental component of a successful program of continuous education is close association in the planning and information phases between the medical schools and the medical community involved.

3. Methods of evaluating programs are urgently needed, dealing not only with professional excellence but also with effectiveness in terms of numbers of individuals involved and response to their needs.

4. Regional studies and interchanges of information in areas with similar problems were proposed, emphasizing the value of sharing experience in the use of special techniques, periodicity of programs, content problems and other matters related to the special character and circumstances in the local physician population.

5. A meeting of the committee is planned in Chicago at the time of the Council meetings in February, and leading up to this meeting there will be active consideration of additional membership suggestions with particular reference to regional distribution.

Acceptance

The annual report of the Committee on Postdoctoral Education was accepted without revision at the Business Meeting, Tuesday, October 30.

Committee on Public Information

LOREN CHANDLER, acting chairman: American medical schools have a great story to tell. Medical education, research and health service have great news value. We have done a poor job of telling our story.

Our medical schools should give information and publicize themselves in the following ways:

1. Intra-university publicity. There are three main channels through which this type of publicity may be achieved. First, university publications such as house organs or alumni journals may be utilized. Second, medical school faculty conferences and meetings, to which members of the faculty from social and clinical sciences, law and other college departments are invited, may be used. Third, some procedure or technique may be established whereby the university board of trustees is kept well informed about the medical school.

2. Public information activities at the local community and state level with the medical profession. Information also should go to medical and nonmedical university alumni, the lay public, industry and others.

3. Establishment of practical working arrangements with local newspapers, news services and radio and television stations. This may be accomplished by means of personal acquaintance, learning each other's ethics and code, telling the entire story, being available for the press 24 hours a day, inviting science writers frequently to meet, talk and lunch with faculty members.

Other methods of establishing working arrangements may include the preparation of feature stories on education and research; conducting displays and conferences on medical education; research and service; medical school participation in the medical seminar of the American College Public Relations Association.

4. Establishment of an Association of American Medical Colleges public information office with adequate budget, directed by a full-time, experienced public relations man, preferably one with experience in journalism. Such an office could do all the above things at the national level on behalf of all medical schools. It also could cooperate with the National Fund for Medical Education, various foundations, federal and state departments and other groups. It would be available to advise and help individual schools with their public information efforts.

Acceptance

The annual report of the Committee on Public Information was accepted without revision at the Business Meeting, Tuesday, October 30.

Committee on Student Personnel Practices

CARLYLE F. JACOBSEN, chairman: The

director of studies, John M. Stalnaker, has prepared for the committee, and under its direction, the following report:

The work of the Committee on Student Personnel Practices is handled through committee meetings and the work of a permanent staff located in the Association office under the director of studies who is responsible to the committee. The work is financed by special grants and revenue from testing. The committee met on October 15, 1950, and again on June 2, 1951. The following activities have been under way during the year under report.

1. The Medical College Admission Test was administered for the committee by the Educational Testing Service on November 6, 1950, and May 12, 1951, at 276 supervised centers located throughout the country. Although the committee has hoped that the May test would be the chief administration, 8,555 applicants took the test in November as contrasted with 6,407 in May. Thus a total of 14,962 students were tested. Over 70,000 individual score reports were sent to the medical schools during the year. In addition, each school is sent a book listing every student tested and his scores.

Reports of score distribution of the applicants to each medical school were prepared and sent to that school. Distributions of scores for the undergraduate colleges also were prepared and sent to the individual colleges for their information and guidance. The committee has voted, for the future, to prepare these distributions for students from the undergraduate college based on the past five test administrations and to send reports to all undergraduate colleges which had 10 or more students tested during this period. These reports are confidential and not for publicity purposes.

The pattern of the test has not changed during the past year. Work is being done on developing new types of items and attacking new areas for measurement which might be significant in the admission work.

A committee of leading educators, under the chairmanship of Dr. Dayton Edwards of Cornell, has directed the preparation of the science section of the test.

The M.C.A.T. is designed to consist of material of intrinsic and well established validity. Each medical college makes the use of the test results which it believes to be most appropriate to meet its needs. In addition to studies which are undertaken by the individual medical schools of the value of the tests, the committee is undertaking to establish permanent records of the individuals admitted to medical school so that the various types of validity studies can be undertaken in the near future.

2. Periodic cumulative lists of accepted applicants were again published. The first list, prepared on November 30, 1950, contained 349 names, and the 14th and final list, published on August 17, 1951, contained 6,289 names. These lists are of value to some of the schools and continuation of them is planned. Early reporting of accepted applicants is requested. Late admission policies or clerical difficulties prevented five of the schools from reporting a single applicant in time to be included in the list published on August 17, 1951. Earlier reporting would improve the value of these lists.

3. A report of the applicants for admission to the class entering in the fall of 1951 is now in progress. This study cannot be undertaken in its final phases until all reports from the individual schools have been submitted. Because two schools did not submit their reports until after October 11, 1951, the published report has been delayed.

It now appears that slightly more than 20,000 individuals made a total of 71,000 applications for the freshman class entering in 1951. The decline in the number of applicants from the peak year of 1949-50 continues. This year there are some 2,200 fewer applicants, and almost 11,000 fewer applications reported than last year. For the first time, a study is being made of the number of students applying who applied the previous year. It now appears that somewhat over 30 per cent of the applicants are repeats.

A shift from discouraging applicants to encouraging more individuals to apply to medical school may be necessary, especially for some of the schools having restrictions.

The prompt cooperation of most of the medical schools and their willingness to do the necessary checking has greatly aided in the development of accurate statistics in this important area. The problem of definition and the development of adequate and workable uniform rules of procedure will make these statistics even more meaningful in future years.

4. With the aid from a grant from the Markle Foundation, the records of students now in medical colleges and those who have been in attendance during the past five years have been put on punched cards. The accuracy and completeness of

these files are continuing to be checked. It is believed that many types of studies can be made from these records in the near future.

5. The study of drop-outs from medical schools has been delayed, but should be published by the first of the year. Here again, the problem of definition and the adoption of uniform procedures of reporting will make this type of study, which should become routine, of greater value.

6. A 1951 edition of the admission requirements booklet has been published and is available for student use. A charge of $1 per copy is being made this year to help defray the cost of publication. This booklet, first published last year, has been helpful to many students and especially to advisors of students. A 1952 edition is planned. Medical schools should give complete and accurate information for this booklet.

7. A revision of the handbook for students planning to enter medicine has been prepared and is now under consideration by the committee.

8. Work continues on the development of a test to measure interest in the study of medicine. This field of testing is one of the most promising ones. The committee, with the aid of a grant from the Markle Foundation, continues its exploratory work. It is following closely work now being undertaken for the armed services directed toward a differentiation among the interests of students going into the various specialties. Some other approaches to the problem also are being made by other outside groups which the committee is following closely. The committee hopes, in time, to develop a test which will be suitable for use with all applicants.

9. A study of the personality traits of medical students at two of the medical schools, which has been undertaken by Dr. Henry Brosin and supported by the committee, has completed the first phase of its work. This is the type of study which is continuing and does not lend itself to early reporting. A preliminary report has been made, but no significant results leading to changes of existing policies were made. This work has been financed in part by the committee, and to a much larger extent, by a special grant to the committee by the Markle Foundation.

10. The project on techniques and values of the interview in the admission procedure is under study at the University of Utah. A study of the results of this project will be reported during the coming year.

11. A faculty roster of all persons teaching 25 or more hours per year in the medical schools is well along toward completion. This project is being done with the help of the health resources staff of the Office of Defense Mobilization of the federal government. Most of the information supplied by the faculty questionnaires has been coded and put on punched cards. Several preliminary studies have been completed. At the average medical school, physicians provide four out of five hours of all instruction. About three-fourths of the physician-faculty group, however, receive less than half of their earned income from the medical school. On the average, based on the study of 50 of the schools, the faculty hours per student are 534, but over twice this amount was found for three of the schools and four other schools averaged less than 300 hours per student. Of the physician-faculty hours, research accounts for 26 per cent. The average faculty age for the physicians is 46.

The questionnaire approach to securing information of this kind has some limitations. The tendency for the part-time, volunteer person to overestimate the number of hours may be expected. This situation can be investigated on a sampling basis. The consistency of the data in general suggests that the results will not be without value.

If the values of a study of this type appear to be great enough, efforts will be made to maintain this faculty roster on an up-to-date basis by either annual or biennial corrections. The complete punched card file, which is being prepared by the government, will be available in the Association office before the first of January.

12. A statistical study of the freshman class which entered in 1950 is now nearing completion. It is expected that a published report, including the names of all of the students and their classifications together with a statistical summary, will be published within the next few months. The test scores, age, state of residence and many other items will be summarized by medical school for this group. This class will then be followed through the subsequent years of their medical education.

13. The committee handled the dry run of the matching plan for internship placement. The director of studies and the entire staff devoted a large amount of time

to this work. The plan, if supported by the hospitals and the students, is a feasible one. The mechanical aspects of the plan, which should belong in the background, have been stressed unduly and the value of the plan, both for the hospitals and especially for the students, has not been stressed sufficiently.

The committee has lent, without charge, its director of studies to be the director of operations for the newly formed Inter-Association Committee on Internships.

14. The committee has received an increasing number of requests for significant types of information which it has not been able to answer. The information, so far as can be determined, does not exist in any central spot at this time. A questionnaire covering a number of these items will be prepared and submitted to the schools in the immediate future.

15. The suggestion of Dr. Olson at the last meeting, that the committee explore the possibility of setting up a central exchange whereby students who have been accepted by any medical school who wish to attend another school be permitted to do so on a one-for-one exchange with the mutual approval of the two schools concerned, has not led to any practical proposals at this time. The committee recognizes the grave dangers of the current state restrictions and notes with some concern the extent to which some state schools are reaching down into the applicant group in order to gain a full class. The problem will be given further study by the committee.

16. The committee again recommends that deposits from accepted students not be required by the medical schools before January 15, or approximately seven months before the class instruction starts. Acceptances could be made earlier, but the committee believes early deposits are unwise. This recommendation is being made to the Executive Council for their consideration.

Acceptance

The annual report of the Committee on Student Personnel Practices was accepted without revision at the Business Meeting, Tuesday, October 30.

Election of Officers for 1951-52

Upon the recommendation of the Nominating Committee, the following officers and members of the Executive Council were duly elected:

Officers:

President—Dr. George Packer Berry
President-Elect—Dr. Ward Darley
Vice-President—Dr. Stanley E. Dorst
Secretary—Dr. Dean F. Smiley
Treasurer—Dr. John B. Youmans

Members of Executive Council 1951-52, and 1952-53:

Dr. Vernon W. Lippard
Dr. Edward L. Turner

The other members of the Executive Council, elected last year for a two-year term, are Dr. Joseph C. Hinsey and Dr. C. N. H. Long.

Dinner Meeting

Sir James Spence of Durham University, England, gave an informative address at the dinner meeting, Tuesday, October 30. He described in detail the means by which government support for higher education is obtained without political control over the universities. This financial assistance is made possible, he said, through the University Grants Committee.

Executive Council Meeting Actions

The meeting of the new Executive Council was held on the evening of Tuesday, October 30. A summary of actions taken at the meeting follows:

1. Dr. Joseph C. Hinsey was elected chairman of the Executive Council for the year 1951-1952.

2. Upon the recommendation of the Committee on the Journal of MEDICAL EDUCATION, authorization was granted the editor and managing editor of the Journal to begin the publication of a 10 issue Journal beginning January 1953.

3. A budget of $59,380.71 was approved for the Medical Audio-Visual Institute (formerly the Medical Film Institute) for the year 1951-1952.

4. The name of the Committee on Post-doctoral Education was changed to the Committee on Continuation Education.

5. An ad hoc committee consisting of Drs. Berry, Dorst, Long, Smiley and Stalnaker was appointed to develop plans for a series of teaching institutes.

6. A committee consisting of Drs. Darley, Lippard and Turner was appointed to study and bring in a report on the long-range functions of the Association.

7. Dr. Joseph C. Hinsey was authorized to represent the Association at the inauguration of Harlan Henthorne Hatcher as eighth president of the University of Michigan, November 27, 1951.

8. Committees and representatives to

other boards and councils for 1951-1952 were named as follows:

(Chairman listed first—Affiliation listed in italics)

AUDIOVISUAL EDUCATION

Walter A. Bloedorn, *George Washington*
J. S. Butterworth, *New York University Post-Graduate*
Clarence de la Chapelle, *New York Univ. Post-Graduate*
Joseph Markee, *Duke*
Aura Severinghaus, *Columbia*

BORDEN AWARD

Edward West, *Oregon*
Willard M. Allen, *Washington U. (St. Louis)*
C. N. H. Long, *Yale*
H. P. Smith, *Columbia*
Ashley Weech, *Cincinnati*

CONTINUATION EDUCATION

John Truslow, *Virginia Medical College (Richmond)*
George N. Aagaard, *Southwestern*
Robert Boggs, *New York University Post-Graduate*
Kendall Corbin, *Mayo Foundation (Rochester)*
Aims C. McGuinness, *Pennsylvania*

ENVIRONMENTAL MEDICINE

Duncan W. Clark, *State Univ. of New York (N.Y.C.)*
Jean A. Curran, *State University of New York (N.Y.C.)*
Harry F. Dowling, *Illinois*
William W. Frye, *Louisiana State*
David Rutstein, *Harvard*
Leo Simmons, *Cornell*
Ernest Stebbins, *Johns Hopkins*

FINANCIAL AID TO MEDICAL EDUCATION

Vernon Lippard, *U. of Virginia (Charlottesville)*
George Packer Berry, *Harvard*
Walter A. Bloedorn, *George Washington*
Ward Darley, *Colorado*
Joseph C. Hinsey, *Cornell*
Maxwell Lapham, *Tulane*

FOREIGN STUDENTS

Francis Scott Smyth, *California (San Francisco)*
Maxwell E. Lapham, *Tulane*
C. N. H. Long, *Yale*
Harry A. Pierson, *Institute of International Education*
Aura E. Severinghaus, *Columbia*
Edward L. Turner, *U. of Washington (Seattle)*
Elizabeth Lam, *International Exchange of Persons*
E. Grey Dimond, *Kansas*
Frode Jensen, *New York University Post-Graduate*

INTERNSHIPS AND RESIDENCIES

John B. Youmans, *Vanderbilt*
D. W. E. Baird (Ida., Mont., Ore., Wash.), *Oregon*
Parker R. Beamer (Ky., N.C., S.C., Tenn.), *Bowman Gray*
W. A. Bloedorn (Del., D.C., Md., Va., W. Va.), *George Washington*
Warren T. Brown (Okla., Texas), *Baylor*
L. R. Chandler (Ariz., Calif., Nev.), *Stanford*
J. A. Curran (Conn., N.Y., Part of N.J.), *State U. of N.Y.*
Charles A. Doan (E. Ohio, W. Penna.), *Ohio State*
Stanley Dorst (Mich., W. Ohio), *Cincinnati*
Reginald Fitz (Me., Mass., N.H., R.I., Vt.), *Harvard*
Maxwell E. Lapham (Ark., La., Miss.), *Tulane*
H. C. Lueth (Kans., Mo., Nebr., N.D., S.D.), *Nebraska*
John McK. Mitchell (Part of N.J., E.Pa.), *Pennsylvania*
Otto Mortensen (Minn., Wis.), *Wisconsin*
Francis J. Mullin (Ill., Ind., Iowa), *Chicago Medical*
C. J. Smyth (Colo., N. Mex., Utah, Wyo.), *Colorado*
R. Hugh Wood (Ala., Fla., Ga.), *Emory*

Journal of MEDICAL EDUCATION

Lowell T. Coggeshall, *University of Chicago*
James Faulkner, *Boston*
Robert A. Moore, *Washington University (St. Louis)*

LICENSURE PROBLEMS

Charles A. Doan, *Ohio State*
William R. Willard, *State U. of N. Y. (Syracuse)*
John P. Hubbard, *Pennsylvania*
J. Murray Kinsman, *Louisville*

LONG RANGE PLANNING

Ward Darley, *Colorado*
Vernon Lippard, *U. of Virginia*
Edward Turner, *U. of Washington*

MEDICAL CARE PLANS

D. F. Smiley, *Association of American Medical Colleges*
Lowell T. Coggeshall, *University of Chicago*
John F. Sheehan, *Loyola*

MEDICAL ROTC

Stanley Olson, *Illinois*
Lawrence Hanlon, *Cornell*

Stockton Kimball, *Buffalo*
John Lagen, *California (San Francisco)*
John B. Youmans, *Vanderbilt*

NATIONAL EMERGENCY PLANNING
Stockton Kimball, *Buffalo*
George Packer Berry, *Harvard*
John Z. Bowers, *Utah*
Stanley Olson, *Illinois*
John M. Stalnaker, *Association of American Medical Colleges*

PLANNING FOR TEACHING INSTITUTES
George Packer Berry, *Harvard*
Stanley Dorst, *Cincinnati*
C. N. H. Long, *Yale*
D. F. Smiley, *Association of American Medical Colleges*
John M. Stalnaker, *Assoc. of American Medical Colleges*

PROGRAM COMMITTEE
Dean F. Smiley, *Assn. of American Medical Colleges*
George Packer Berry, *Harvard*
Robert Lewis, *Colorado*
Harold Lueth, *Nebraska*

PUBLIC INFORMATION
L. R. Chandler, *Stanford*
George N. Aagaard, *Southwestern*
John L. Caughey, *Western Reserve*
Ralph Rohweder, *National Society for Medical Research*
Dean F. Smiley, *Association of American Medical Colleges*
John D. Van Nuys, *Indiana*

STUDENT PERSONNEL PRACTICES
Carlyle Jacobsen, *State University of New York*
George Packer Berry, *Harvard*
D. Bailey Calvin, *Texas*
John Deitrick, *Survey of Medical Education*
Thomas Hunter, *Washington University (St. Louis)*
Richard H. Young, *Northwestern*

VETERANS ADMINISTRATION-MEDICAL SCHOOL RELATIONSHIPS
R. Hugh Wood, *Emory*
Harold Diehl, *Minnesota (Minneapolis)*
Reginald Fitz, *Harvard*
R. Arnold Griswold, *Louisville*

Representatives to Related Organizations

ADVISORY BOARD FOR MEDICAL SPECIALTIES
L. R. Chandler
Stanley Dorst

ADVISORY BOARD OF AMERICAN FOUNDATION OF OCCUPATIONAL HEALTH
Dean F. Smiley

ADVISORY COUNCIL FOR THE NATIONAL FUND FOR MEDICAL EDUCATION
Arthur C. Bachmeyer
Walter A. Bloedorn
Joseph C. Hinsey

ADVISORY COUNCIL ON MEDICAL EDUCATION
Ward Darley
Joseph C. Hinsey
Vernon W. Lippard

AMERICAN COUNCIL ON EDUCATION
Rev. Paul A. McNally
William T. Sanger
William R. Willard

ARMED FORCES MEDICAL ADVISORY COMMITTEE
Stockton Kimball

COMMITTEE FOR THE COORDINATION OF MEDICAL ACTIVITIES
Dean F. Smiley

COMMITTEE ON SURVEY OF MEDICAL EDUCATION
Arthur C. Bachmeyer
Joseph C. Hinsey
Dean F. Smiley

COUNCIL ON NATIONAL EMERGENCY MEDICAL SERVICE
Stockton Kimball

EVALUATION OF FOREIGN CREDENTIALS
Frances Scott Smyth
Dean F. Smiley

FEDERATION OF STATE MEDICAL BOARDS
Dean F. Smiley

FELLOWSHIPS SELECTION BOARD
Walter A. Bloedorn

INTERASSOCIATION COMMITTEE ON INTERNSHIPS
F. J. Mullin
John M. Stalnaker
John B. Youmans

JOINT COMMITTEE ON MEDICAL EDUCATION IN TIME OF NATIONAL EMERGENCY
Stockton Kimball
George Packer Berry
Joseph C. Hinsey
Dean F. Smiley
John M. Stalnaker

LIAISON COMMITTEE WITH COUNCIL ON MEDICAL EDUCATION AND HOSPITALS
George Packer Berry

Stanley Dorst
Joseph C. Hinsey
Dean F. Smiley, ex-officio

MEDICAL ADVISORY COMMITTEE OF INSTITUTE OF INTERNATIONAL EDUCATION
Duncan W. Clark
Dayton Edwards
Aura Severinghaus
Francis Scott Smyth
Travers C. Stepita

NATIONAL ADVISORY COMMITTEE ON LOCAL HEALTH UNITS
Currier McEwen

NATIONAL BOARD OF MEDICAL EXAMINERS
L. R. Chandler
Robert A. Moore
B. O. Raulston

NATIONAL HEALTH COUNCIL
Joseph C. Hinsey
Ira Hiscock
Currier McEwen

Wednesday, October 31, 1951

Summary of Round Table Discussions

Panel discussions on the topics that follow were held on the first day of the Annual Meeting. Round Table members are listed on page 7. The following reports are summary statements by the chairmen or recorders for each group, and were presented Wednesday morning, Oct. 31:

Round Table 1

Regional Hospital Plans and Continuation Education of Physicians

R. H. Kampmeier, chairman.

The chairman opened the discussion by stating that medical schools should and must be interested in the level of medical practice in their communities. Furthermore, the schools should give the assistance necessary to maintain professional adequacy in the care of the patient. It was indicated that the regional hospital offers an important facility for continuation education of the practitioner. The presentations by the members of the panel were designed to cover:

(1) The need for continued study on the part of physicians in private practice and methods by which this can be accomplished.

(2) The content of continuation education for physicians.

(3) Continuation study in regional hospitals on a house-staff level.

(4) The use of the regional hospital as a teaching center by visiting teachers from medical centers.

These discussions and questions and comments from the floor developed certain aspects which may be summarized as follows:

First, house staff training in regional hospitals. In some areas experience has been gained in the rotation of residents selected by affiliated community hospitals through a university hospital. A plan was described in which the resident, after a year in the affiliated hospital, spends an equal time in the University of Michigan hospital to obtain training mainly in the basic sciences. Subsequently he returns to the affiliated hospital to complete his residency and extend his clinical experience. The Kellogg Foundation initially covered the cost of this program. It now is being borne by the University of Michigan and the physicians practicing in the affiliated hospitals.

An example of hospital affiliation for intern training was described as developed by the Medical College of Virginia, through the aid of the Commonwealth Fund, and now with the participation of the University of Virginia. This plan provides for a six-week to three-month experience on the part of the intern in a hospital affiliated with the university hospital.

The general discussion developed the large part that such house staff programs play in the postgraduate education of the physicians in the community in which the affiliated hospital is located. Since such programs are possible only if members of

the university hospital staffs make periodic teaching visits to the affiliated hospital and only if certain members of the staff of the hospital assume the obligation of teaching the house staff, donating much of their time and energy, such activities must result in a higher level of practice in the hospital. If the private patients of the hospital are used as teaching cases, again the level of practice cannot help but be improved. The betterment in medical records, laboratory and other ancillary facilities must certainly be reflected in better care of the sick of the community. The part the visiting pathologist plays is of inestimable value in the reduction of unnecessary operations.

Discussion also brought out the constant need for supervision of the policies of the affiliated hospitals to assure no lag in teaching interest on the part of the staff, nor the degeneration of a teaching program into the utilization of the house staff as mere service personnel. It was felt that the costs of such programs must be laid in large part on the shoulders of the affiliated hospitals. These house-staff programs have resulted in some instances in the location of young doctors in nonurban communities.

Second, continuation education of physicians in practice. This subject permitted descriptions of a number of systems in use. In some instances educational programs have been begun by medical societies; in others the medical schools have taken the initiative in establishing postgraduate instruction for doctors. In either case, the collaboration of state medical societies and other bodies is highly desirable.

One of the methods of instruction utilized by the New England Medical Center consists of supplying the family physician with a complete transcript of the patient's hospital record on the occasion of hospitalization. This represents a case demonstration on the physician's own patient. It is accompanied by abstracts of teaching material culled from the current literature.

A common method of providing continuation training is the so-called "circuit-riding" type, by which members of the university hospital staff visit smaller communities to instruct physicians of a given area. The several methods described by the members of the panel varied only in detail. It was generally agreed that such teaching should be clinical and not didactic, that patients of the local doctors should provide the material for case discussions and that the teaching be carried out in the local hospital. The need for establishing regularity in such visits was emphasized so that such teaching services become a part of the doctor's routine. In some states this type of teaching has reached a high proportion of the physicians in the rural areas.

The "circuit-riding" type of continuation education amplifies and complements the refresher type of teaching given in one to five-day sessions at the university hospital. This type of instruction has had a background of years of experience in some of the schools represented by members of the panel. Again the content and details vary, but such courses permit possibly more organized and specialty presentations than does the "circuit-riding" type.

An interesting training development in the Kansas postgraduate plan is the designation, by one means or another, of one practitioner in a community to become the interpreter of laboratory findings, another of x-ray films, another for anesthesia. These men receive varying periods of training at the university hospital.

The general discussion included the various methods of financing the activities of continuation education. In the field of house-staff training by hospital affiliation, it was felt the hospital should assume the major burden of the expense. However, in the case of state supported medical schools, they may make a contribution in terms of staff activities without additional remuneration. Foundations have played their part in the development of these plans.

In the field of postgraduate education it was brought out that tuition paid by registrants may well carry the expense of refresher courses. Similarly, a tuition fee may contribute to the "circuit-riding" type of education as also do special agencies with moneys collected for the control of certain diseases. More effort should be made to obtain contributions from state medical societies and the Academy of General Practice, as is already done in some areas.

Finally, there was extended discussion as to just what continuation education of the practitioner has accomplished. Has it led to better medical care of the sick in the nonurban areas? It was generally agreed that this question cannot be answered by any statistical or scientific means. The only evaluation at the present time is that of impressions on the part of those engaged in postgraduate teaching; admittedly these may be biased by enthusiasm. Nevertheless, it seems that im-

provement in medical records and better utilization of diagnostic aids in the small hospital may offer some concrete evidence of a measure of success. The more pointed questions and better case analysis, as evaluated with the passage of time by the "circuit-riding" teacher as he makes his rounds, offer evidence of better thinking in relation to medical problems than a year or more before. Of necessity professional ethics must improve as doctors in a community are thrown together in a common project for their mutual improvement, and as each is humbled in the other's presence in case discussions which point up errors in diagnosis and judgment.

Members of the panel and discussants from the floor at no time raised any question as to whether continuation education is to be discarded. The need for such education is without question. The problems which remain are: first, which methods of teaching will give the best results, and second, how may these results be measured.

Recommendations:

(1) The panel members recommend that study should be given to developing methods whereby an evaluation may be made of the impact of continuation education upon the quality of medical care in a community;

(2) Furthermore, that methods be explored for encouraging practitioners to participate in continuation education.

Round Table 2

The Threat of Large Scale Research Programs to the Quality of Medical Education
***Richard H. Young*, chairman.**

As a result of wide general discussion the following conclusions were reached:

1. That large scale research programs represent no threat to the quality of medical education provided they are administered wisely, both by the granting agencies and the recipient institutions.

2. That the best guarantee for sound administration on the part of the granting agencies is the system of broad representation from universities and colleges on the councils that develop their policies and on the panels of experts that scrutinize applications.

3. That many of the problems which are raised by large scale research programs would be met if the teaching programs in medical schools were adequately financed.

4. That a resolution be presented to the Executive Council recommending that the Association of American Medical Colleges undertake a study to determine the actual cost, direct and indirect, of research, with a view of reaching a more adequate and uniform basis for discussion of overhead charges with fund-granting agencies.

Round Table 3

Medical Teaching on the Ambulant Patient
***David Barr*, chairman.**

Dr. Barr described the intrinsic features which have brought medical education to its outstanding position in our modern society. In a large measure this was attributed to careful and meticulous attention to anatomical and chemical defects with remarkable and inspiring advances in the solution of such problems. However, there is a distinct danger that such a procedure can, and in fact often does, become a sterile intellectual exercise with little regard for the understanding or appreciation of the patient and his problem.

It is essential that the student be taught to evaluate the social, economic, emotional and environmental factors in the patient's day-to-day life which often are of the utmost importance in respect to the proper understanding of the illness situation. He must consider the patient and his family as well as the disease, and evaluate the significance of one in relation to the other. It is essential, therefore, that the student become familiar with the background of disease from a comprehensive point of view.

Ward teaching in many instances has reached a peak of unparalleled excellence, yet it inherently retains certain specific limitations. It represents an exercise which deals with but a small component of the total number of sick people. It is an experience which deals with a brief and isolated circumstance in the patient's life rather than the result of a prolonged period of observation. Perhaps most significantly it represents a conclusion based on a series of observations on a subject who has been displaced from his normal milieu, and thus may be deceiving and artificial.

The obvious solution lies in the increasing utilization of the ambulant patient or the outpatient department. Simple as this answer seems to be, it produces certain problems which deserve careful consideration. Steps must be taken to insure an adequate degree of continuity in patient care and the learning experience. Hurried, strained and brief observations made on the sick person are all too obvious preclusions to good teaching. Measures should

be taken to prevent and control the problem of overcrowding in the clinic. It is desirable that a full-time and dedicated nucleus of teachers form the center around which the instructional staff may be developed. This should include experienced teachers who by precept and example impress on the mind of the student the nature of disease and the significance of the doctor-patient relationship. Of no small assistance would be the interdepartmental correlation of clinical activities which bring to bear on any given problem the special skills, experience and knowledge which will be of benefit to both patient and student. In this vein there must also be included additional facilities for medical care such as the visiting nurse and social service departments.

Ultimately, in order to appreciate fully the significance of social, economic, emotional and environmental factors as they relate to illness situations, medical education must include facilities which will make it possible for the student to study the patient in his normal environment, namely, the home. In this respect it also may be wise to consider the inclusion of the humanities in the mainstream of medical education.

Dr. Lester J. Evans: The interest in the medical care of the ambulant patient and the use of the ambulant patient for medical teaching purposes are symptomatic of this present period of transition in medicine. The ambulant patient is becoming a symbol of forward-looking medical development.

The historical perspective of medicine as viewed over the last 40 or 50 years gives indication why the ambulant patient is becoming increasingly a principal focal point of medicine.

"As we view the historical perspective of medicine, it seems to me that development has been along three principal routes or avenues which have now reached a point of confluence or merger. These routes are scientific clinical medicine, public health, psychiatry and social studies.

"Scientific clinical medicine has resulted from phenomenal advances in the medical sciences whereby the nature of many disease processes has been revealed. The disease was the point of departure. Knowledge of the normal accrued largely as a by-product. The host was studied only as it became necessary to understand a disease process. In our modern educational system the university medical center has become the symbol of scientific medicine. It is there that the findings of the basic science laboratory are translated into study of human physiology and pathology. The teaching and research hospital is the principal focal point around which the growth of medical education has taken place in the last 40 years.

"Paralleling the development of scientific medicine there grew up in the community, and in fact outside university and medical education circles, many activities which are collectively referred to as public health. The concept of prevention in modern medicine stems from the success in first preventing the spread of communicable or infectious diseases by attacking certain environmental situations, and next by altering the character of the host through immunological procedures so it was no longer susceptible to specific infectious agents. So popular has the concept of prevention become that it has been carried to almost hazardous extremes by holding out false promises in fields where little is known of the nature of health or illness processes. The scientific underpinnings of public health derive from the basic sciences of medicine. The principal original contribution from public health to scientific procedure has been the brilliant application of the quantitative method to the study of community and other mass phenomena. This is one way in which medicine has had opened up to it the opportunity to study the human being in relation to the events taking place in his natural environment.

"Offhand it might seem that we now have all that is needed to interpret the health and illness of human beings as an adaptive process—the dynamic relationship between the organism and its environment. But that cannot be done without turning to a third stream of medical progress which is emerging through psychiatry and psychology. Modern psychiatry has helped us understand that the human being really functions as an integrated whole. The evidence has come most strikingly from the joint efforts of psychiatry and scientific medicine in the study of the relationship of such phenomena as hypertension, asthma, gastric ulcer and headache to the life situations of patients. The expression 'life situation' immediately calls for conceptualization in terms of movement through time and in relation to the total environment, the human elements of it as well as the infectious, physical or nutritious. Thus the dynamic nature of life processes is further emphasized and the human element of environment stands out in bold relief.

"It seeems to me that the development of medicine in recent decades, as I have tried to describe it, brings us to a point where we can approach the study of medicine on a somewhat broader basis than has been customary. Instead of thinking primarily of specific fields, departments and skills, possibly we are now in a position to think more clearly about the basic biological concepts which are involved and which can be used in the planning of our future educational efforts. I refer to such concepts as the integrity of the living organism (wholeness), growth and development (movement), organism-environment relationships (relationships), and other basic phenomena of which you are well aware. These give meaning to the expression 'dynamic' as now used in medicine and biology in understanding the forces at play and the manner in which they affect the development and behavior of the living organism." [1]

Of these basic concepts it is that of the organism-environment relationship which interests us most in this discussion. (a) The ambulant patient is never entirely removed from his environment. (b) The ambulant patient is not studied at one sitting but rather through a series of contacts through time. (c) As the interest of medicine moves toward a consideration of the environment, we can follow the ambulant patient into that environment quite easily. (d) This environment is, as we have pointed out, all inclusive.

The human environment is actually society. Thus, by dealing with the ambulant patient in all aspects of his living, we are dealing with him in society. But to understand society, medicine needs much help from the sociologist, social psychologist, cultural anthropologist, economist, political scientist and so forth.

As medical education gives increasing emphasis to the environmental component of the organism-environment complex, medical teaching institutions in one way or another will in the years to come develop outdoor laboratories. These outdoor laboratories may quite well attain the significance in the years to come that the indoor laboratories of medical education—the hospital ward, the basic science laboratory and so forth—have in past decades.

[1] "The Metamorphosis of Preventive Medicine" by Lester J. Evans, M.D., Commonwealth Fund, New York. *Conference of Professors of Preventive Medicine Newsletter*, Vol. 2, No. 1, March, 1951.

We end up, therefore, with the proposition that whereas medicine has developed up to this time primarily around the problem of the bed patient, medicine of the future is quite likely to grow and evolve around the problem of the ambulant patient. It is around the ambulant patient that some of the newer fields of medicine and the newer concepts of medical care such as preventive medicine, psychosomatic medicine, newer and broader uses of public health, the hospital and other facilities will evolve.

Dr. Stanley Dorst: Dr. Dorst looked back some 25 years to consider what were at that time the fundamental thoughts in respect to adequate teaching in the dispensary. This included five major objectives. The first was to create dispensary facilities which would reproduce as nearly as possible the pattern of private practice. The second was to develop an appointment system which would provide a satisfactory degree of continuity for both student and patient. The third element was the creation of facilities which would control and disperse the patient load in such a fashion that education could go on unimpaired and patient care continue at a satisfactory level without overwhelming the staff. The fourth requirement was to provide a sufficient block of time in the curriculum for the student to become properly and adequately oriented in the problem of medical care in dealing with the ambulant patient. The fifth and perhaps the most significant point was a conviction that senior members of the staff had a personal responsibility for teaching and patient care in the outpatient department.

These were the thoughts which eventually materialized at Cincinnati. The physical establishment to accomplish these aims became a reality. Students were provided with a four-month experience in the clinic with the same instructors and functioned in a central office and examining area. It was felt that good teaching resulted from following this preconceived pattern. It was further indicated that if an outpatient department was unsatisfactory as an educational experience, it was because the teachers were second-rate. Therefore, every member of the medical staff was required to assume responsibility for the outpatient department as well as the inpatient service.

There also were difficulties which were not apparent at the onset. The appointment system resulted in a piling up of patients and the consequent need for a screening procedure. This was accom-

plished by the development of a preclinic which provided for patient selection and distribution. It also became apparent that some measures were necessary for the disposition of emergency situations and patients with acute short-term illnesses. The answer to this problem proved to be a receiving clinic in which patients could actually be retained for treatment for as long as 24 hours. A third problem was the specialty clinics which gradually continued to expand and siphon off patients. The correction of this problem was obtained by the simple expedient of converting the specialty clinic to referral clinics so that they could return to their intended function of providing a consulting service.

Dr. Henry J. Bakst: The home medical service of the Boston University School of Medicine operates within the administrative framework of the outpatient department of the Massachusetts Memorial Hospitals. This activity provides medical care in the homes of those needy and medically needy individuals living in the south end of Boston and an adjacent portion of Roxbury who request its services. This slum area contains a population of about 50,000. Some 15,000 home visits are made to 5,000 patients annually. About 35 per cent of the patients cared for are recipients of some form of official financial assistance, such as general relief, aid to dependent children and old age assistance. The responsibility for the provision of medical care in this area has been a function of the Massachusetts Memorial Hospitals for more than 75 years. During this time it has served as an educational activity of the medical school. The utilization of this service as an educational facility is the responsibility of the department of preventive medicine.

Fourth-year students, carefully supervised, are given a great deal of responsibility for patient care. Actually about 75 per cent of the patients on this service are cared for at home. About 7 per cent of the patients are hospitalized at either the Massachusetts Memorial Hospitals or the Boston City Hospital. The remainder are referred to the outpatient department for further investigation.

The organization of the administration of medical care for patients on this service parallels that of care within many teaching hospitals. Patients are seen by fourth-year students, checked by residents and supervised by the hospital staff. There is, however, one striking difference in that the student sees the patient first, in the patient's home and, throughout his experience, the student is the individual through whom medical care is made available to the patient. A very specific and successful effort is made to maintain the student in the position of family doctor or general physician for the area to which he is assigned. The supervising residents, instructors and those who provide special services act in the capacity of consultants and advisors. The reaction of the student to this experience has been most gratifying and stimulating.

The educational benefits of this program present a number of interesting aspects. Such a service requires that those responsible for instruction teach clinical medicine on a very practical level. The problems of adequate patient management in the home must be anticipated to avoid straining or embarrassing the student's relationship with his patients. The preventive aspects of disease as related to the individual and his family and the significance of social, environmental and emotional factors on illness situations are frequent problems of major concern. A source of constant gratification is the surprising rapidity with which students who are obviously diffident and anxious at the onset of the assignment become confident and assured. Students, almost without exception, develop a broad sense of social responsibility which has been one of the most satisfying dividends of the entire program.

The learning process in medicine beyond preclinical training and familiarity with the natural history of disease is largely a matter of active participation in a clinical medium. In this regard, two considerations of the utmost significance are those related to the extent of personal responsibility which the student is allowed in his clinical activities, and the degree of continuity which is possible in his relationship with patients. While a significant degree of responsibility is given to students on the home medical service, a one-month continuity assignment is obviously too brief a period to provide a significant degree of continuity in patient care. In order to meet this need, among other reasons, a family study program was instituted within the framework of the home medical service.

This venture was instituted three years ago. It consisted of selecting from the regular clientele of the home medical service a family for each member of the third-year class. These families were assigned at the onset of the third year. The criteria for family selection were that the

family unit include several young children and one member with a chronic illness. A detailed outline of the objectives of the assignment was given to each member of the class. A preliminary report on the family was required in three months and the student continued as the medical advisor to his family throughout the third and fourth years. Since the fourth year operates on a 12-month schedule, each student followed his family for a period of about 20 months.

The objectives of this program included:

1. Supervised responsibility of the student in the medical management of such acute problems as arose during the period of the assignment.

2. Observation and responsibility for the medical management of a chronic illness in the home.

3. Immunization of children and the development of concepts of disease prevention within the family unit.

4. Evaluation of social, environmental, emotional and economic factors in relation to illness situations in the family.

5. Development of familiarity with public and private resources for medical care in the community.

A final report was required of each student in the latter half of his fourth year. An interesting outcome of this program was a series of panel discussions in which families illustrating problems in tuberculosis, diabetes, epilepsy, rheumatic heart disease or asthma were held with the entire third-year class. The student presented a summary of his "family" and the pertinent illness situation. This was followed by a brief discussion by each member of the panel, which included a representative from the departments of medicine, psychiatry and preventive medicine as well as social service. The objective was to discuss the specific problem from the clinical, emotional, preventive and social points of view. The presentation by panel members was followed by a general discussion in which the entire class participated. These exercises proved to be one of the most popular in the third year.

Three additional features were essential elements in the family study program. A psychiatrist, who is a member of the department of preventive medicine, conducted a series of individual conferences with each member of the class. The initial meetings were concerned with interviewing techniques and the approach to a patient. Subsequent conferences dealt with the evaluation and interpretation of the accumulated material and, finally, a discussion of patient management.

A second series of conferences was conducted by an older, experienced and able internist, who met the class in small groups for a series of general discussions. These were based on questions raised by students in respect to the proper management of various problems encountered in the home. Two younger practicing physicians were available daily, on a part-time basis, to accompany the student to the home in order to check physical findings and to control the management of current problems as well as outline the program for long-term care.

Inclusive and satisfactory as this program appeared to be, a series of pitfalls quickly became apparent. Students readily detected an artificial aspect of the program in that the families to whom they were assigned, although in need of medical care, did not actually request medical attention. A review of the reports made it amply clear that students were unprepared to approach and observe a family group in the outlined manner. Except in unusual instances, the student was apt to disperse his efforts among various members of the family together with an obvious tendency to stress social issues to the detriment of the clinical problems with which he was confronted. Not the least difficulty was the usual dispersion of fourth-year students in various hospitals and assignments so that for varying periods they were either not available or did not have sufficient time to visit their families. Despite these handicaps, the rapport which many students developed was of such a nature that preceptors found it unwise to advise a patient directly after being told by several that the advice would be followed only if the "family doctor" agreed.

This year, although the essential structure and objectives of the program have remained unchanged, each student in the third-year class was assigned to a patient with a chronic illness. The patient is to be followed during the third year only. Out of this contact it is hoped that students will be consulted when illness develops in other members of the family. This is, in fact, the natural development of events in any family practice. It is felt that the degree of success in the extension of medical care to other members of the family will inevitably be a reflection of the relationship established with the assigned patient. This already has been noted as a frequent occurrence. The advantage of the single patient assignment within a family unit is

primarily in the opportunity it provides for the student to relate his experience in medical care to a sharply focused responsibility rather than the diffuse artificiality of a family assignment.

Three years of experience in this area has emphasized clearly that the student develops an appreciation of the need to understand a patient in relation to his life history and total environment. He is keenly aware of his responsibility for a human being rather than a symptom or a disease.

What is visualized as an ideal goal in the integration of a home care program in the medical curriculum is in reality quite different from that which is in operation at present. It consists of a morning assignment in a general medical clinic in which the student would function essentially as any physician in his own office. The attending physicians or instructors would serve in the capacity of consultants or advisors. The afternoons would be spent on the home medical service. The student could thus see his patients on both an ambulatory and non-ambulatory basis. During this period he also should have free access to the hospital wards in order to follow those of his patients whom he had hospitalized. It is hoped that such reorganization of the entire program may be instituted in the near future.

It is probably beyond question that while medical education is concerned with the development of a high degree of technical knowledge and skill, there are also other pertinent obligations. Medical education also should be concerned with emphasizing in the student's experience that the acceptance of responsibility for the welfare of another human being is one of the most significant steps in the art of medicine, an art in which insight and understanding play as important a role as technical knowledge. It is hoped that he will learn too that the core of good medical practice is and will continue to be the relationship between doctor and patient.

Dr. Jacob Horowitz: The Department of Health and Hospitals of the City of Denver and the University of Colorado School of Medicine are establishing a general clinic in the Denver General Hospital. This will represent a joint effort to provide fairly comprehensive medical care for the indigent and medically indigent of the city of Denver and to incorporate within this program the teaching of medical students during their third and fourth years. Patients for assignment to students will be selected from the indigent population and will be followed as members of a family unit. The staff will consist of eight full-time members in addition to voluntary physician teachers, a sociologist, home nurses and social service workers. Full-time members of other clinical departments also will participate in this program.

The chief concerns of this reorientation of school, hospital and health department will be the provision of medical care for the indigent sick of the city of Denver, the further development of general practice internships and the institution of a domiciliary medical care program. Throughout this coordinated project is the careful integration of education at the graduate as well as undergraduate level in the various aspects of medical care.

The problems which have developed are many and varied and include the matters of staffing, physical facilities and records. The staffing of the Denver General Hospital in respect to the divisions of preventive medicine and public health is concerned with the integration of a full-time staff of internist, pediatrician, psychiatrist and general practitioner. Two types of general practice residencies are developing: a two-year program which will prepare men for community practice, and a three-year program directed at rural practice.

The home care service will complete the picture of the hospital as the general practitioner for the indigent of the city of Denver. Medical care will be provided in the hospital, the general clinic of the outpatient department and the home of the patient.

SUMMARY: The lively participation and keen interest from the floor helped to emphasize certain specific factors in respect to medical teaching with the ambulant patient. It appeared generally accepted that the student must not only participate, but must also assume a significant degree of responsibility in the provision of medical care as an important step in the development of his ability to arrive at a better understanding of the sick person. He must also be provided with an appreciable degree of continuity in order to have an adequate learning experience. The feeling was unanimous that the quality of education in this area is directly related to the quality of the teaching staff. It was, therefore, quite apparent that the senior staff must assume responsibility for teaching and medical care on the ambulant as well as the hospitalized person. In this sense it became quite clear that the ambulant patient referred to the non-hospitalized patient, rather than the am-

bulatory person. The need to integrate various clinical departments in the acceptance of responsibility for the comprehensive experience under discussion was only too obvious.

It was pointed out that perhaps one of the most significant techniques in medical education in this country has been the clinical clerkship. It was generally accepted that the objectives of this round table were concerned with the expansion, development and extension of this technique into the outpatient department and the home of the patient. Beyond any question is the desirability for the physician to understand the sick person in relation to his environment and total life history.

It would be unwise and disturbing, however, to close this discussion without clearly indicating an element of potential danger. The use of the outpatient department and home care as a facility in medical education has been visualized for many years. Development in this direction has been delayed by certain extensive and essential preliminary steps necessary to elevate present teaching on the ambulant patient to the level of that attained on the ward. This will require additional financial support obtainable only with great difficulty from existing budgets. In the last analysis, therefore, programs in this direction still must be tentative until the excellence of example is possible.

Round Table 4

Group Practice in Support of Medical Education

A. C. Furstenberg, chairman.

The rather abstruse subject of group practice in support of medical education perhaps needs interpretation. Briefly, the committee who arranged the program for this panel felt that many group practices provide opportunities for instruction of undergraduate students and that ways and means should be found for making this source of teaching material available to members of our senior classes. There was also an implied, if not an expressed, inference that group practice might be considered from the point of view of an ideal way of practicing medicine. This discussion, therefore, deals with two issues: first, the feasibility and practicability of using group practices and group clinics to supplement or augment the teaching programs of medical schools, and second, an appraisal of group practice as a means of rendering medical service. The question was raised, "Are we missing a good opportunity by not utilizing these groups for undergraduate medical education?"

A rather free discussion of this topic gave expression to the belief that medical schools perhaps are missing two important influences in medical education by not affiliating with private medical groups: first, acceptable teaching facilities of a character not usually encountered in a medical school, and second, the introduction of the undergraduate medical student to a form of practice which may be most satisfying from the standpoint of service and an opportunity for his own development, as well.

In respect to the first appraisal, namely, facilities for medical education, it was felt by some of the discussants that in many of the large clinics superior facilities exist for perfecting what one may term the technical aspects of the care of the sick. This opinion was based chiefly on the following factors:

1. Well-balanced departments with a certain level of professional accomplishment are an absolute requirement. In this connection, representatives from a few of the large clinics reported that a third of their clinicians had extensive teaching experience in medical schools and that they were well prepared to deal with pedagogical problems throughout a wide range of medical subject. Clinics in specialized topics could be prepared that would contribute greatly to the undergraduate teaching program.

The motivation of the physicians in these clinics was not questioned. It was stated that they were eager to teach and that private patients were used constantly in a teaching capacity with n many of the clinics for resident instruction, and that this program could be expanded easily to include small or even large groups of undergraduate medical students. The feeling was expressed that these teaching capacities should not be allowed to remain latent, but that mechanisms should be set up to utilize them by our undergraduate medical schools.

2. The second influence of group practice upon the undergraduate medical student, namely, his indoctrination into a satisfying way of professional life, brought forth much discussion. It was argued that an association with a clinic, even for a brief period, probably would clear up certain misconceptions which seem to be held now by many undergraduate students and which necessarily influenced them to select the individualistic form of medical practice.

These misconceptions would be eliminated by:

1. An awareness of the fact that many of the large clinics are NOT organized for profit, but that excess earnings are used to improve facilities for the care of the patient and to promote research.

2. Demonstration that the patient-physician relationship can be preserved in a most intimate manner within a group practice framework. It was pointed out that in most of the clinics a patient is assigned to a physician who is responsible for his guidance along the route of clinical studies. The patient may be transferred from one physician to another, but there is always one doctor responsible for the individual's welfare, who provides a summation of professional opinions, a diagnostic evaluation and therapeutic recommendations. The misconception that patients in a clinic are placed on an assembly line and run through on a mass-production basis would be promptly dispelled. The student would observe that proper regard for personal problems is constantly in evidence. He would learn that there is no standardization of diagnostic methods or operative procedures. On the contrary, the clinic physician, it was argued, often has greater freedom of thought and action than staff members who are practicing in a medical school affiliated hospital.

3. Experience which would dismiss from the student's mind the impression that residents and fellows in clinics often are employed as high-grade professional servants who are expected to carry the load of routine work but offered little in the way of an educational experience. It was emphasized that in many of the large clinics a high percentage of staff men are sincerely interested in teaching the residents and fellows entrusted to them, and are most active in preparing teaching conferences, seminars and technical demonstrations. The feeling was expressed that one often sees a much closer relationship between the resident or fellow and his superior officers than is observed in many of the large teaching hospitals affiliated with medical schools.

4. Observing that a clinic provides an excellent service to the public in offering modern medical care to many persons in the surrounding areas. The student would note also the advantages for members of the medical profession in the neighboring region who have at their disposal the combined clinical, scientific and physical resources of the clinic for consultations, diagnostic and therapeutic measures. Many of the groups in the south and middle west extend their services beyond the walls of their offices into the homes of neighboring residents. To do this they add general practice physicians to their staffs. Thus, they would seem prepared to offer some training in the general practice of medicine to undergraduates, a phase of education which is alleged to be woefully lacking in many of our medical schools today.

In general, it was felt that the senior medical student, confronted with the need of selecting group practice or solo practice to which he will devote his life, would profit by an experience with group practice. He would become acquainted with the resources and physical facilities of groups, their specialized skills, superior qualifications and the favorable economic conditions under which they were offering their services. A familiarity with the historical development of the clinic also would acquaint him with the fact that while there still exists some resistance to group practice, evolutionary changes in medicine are obviously rapidly breaking this down. He would learn that he could have the professional, intellectual and economic advantages of group practice without fear of derision from his professional colleagues.

In conclusion, it was generally agreed that:

1. Group practice offers a valuable educational facility of a variety not always found in a medical school affiliated hospital. The student might profit through utilization of these facilities, but not at the expense of depriving him of any important part of the regular curriculum. The Wisconsin plan of a 48-week instead of a 36-week senior year was recommended for those students who are to be farmed out for a one-quarter period to group practice.

2. That while indoctrination into group practice as a way of life might be desirable, it could, however, be deferred without disadvantage until the period of postgraduate study.

Round Table 5

The Influence of Medical Care Insurance Plans on Teaching Material

Loren Chandler, chairman.

Some of the facts presented and conclusions reached by the panel were:

1. The indigent, medically indigent and low income groups include approximately 80 per cent of our population. This group always has made up a large part of the teaching cases in our medical schools.

2. Approximately 76 million of our population now are covered by hospital insurance, approximately 29 million have insurance including surgical care benefits, approximately 18 million have insurance including medical care benefits.

Five per cent of the population are rich enough not to need medical care insurance.

Ten per cent of the population cannot afford the premiums of comprehensive medical care insurance.

Eighty-five per cent of the population are candidates for comprehensive medical care insurance.

Insurance carriers do not care who provides the medical service as long as the individual or group is professionally competent.

3. An institution cannot legally practice medicine, hence the necessity for organization of the faculty to make it legally able to accept patients for care and accept fees for professional services rendered. There are various ways of doing this.

Once a physician group or faculty accepts a patient, it becomes ethically and legally responsible for the care of that patient at home, in the clinic or in the hospital.

4. The insurer will pay for services or medical care but not for exhorbitant hospitalization costs, extra laboratory tests, research on patients, etc.

5. The use of pay patients for teaching purposes on a voluntary basis is possible and feasible.

Most insured patients are willing to enter teaching wards or services.

Teaching services made up entirely of pay patients may be quite adequate for undergraduate instruction, intern training and training in the nonsurgical specialties.

Pay patients are inadequate for surgical training because the trainee must have full responsibility for the management of his cases including the operation.

6. In one study, the quality of medical care of patients treated by a medical school group was found to be superior to the quality of care provided by individual physicians in the same community.

7. The time spent by the faculty in the clinical departments rendering prepaid medical care was found to be greater than the time spent by most full-time or geographic full-time faculties, but less than the time spent by volunteer faculties.

8. Medical schools must have enough clinical material but must avoid taking too much. Health insurance plans provide one way of getting enough.

9. The Association might well request the practicing medical profession to refer patients in sufficient numbers to fill the clinical needs of our various medical schools.

Round Table 6

The Means of Appraisal of the Medical Student's Progress and of the Effectiveness of Teaching

Robert Moore, chairman.

In planning for the panel it was decided that the "Appraisal of the Medical Student's Progress and of the Effectiveness of Teaching" could not be discussed without some preliminary consideration of conditions which are essential for effective instruction.

It was agreed that the school should create an environment in which a student may develop as a truly educated person and not just as a recipient of facts. Further, we should bear in mind that the student has come to medical school primarily to learn to be a physician and not to be a specialist. Each subject should be fitted into the whole.

One of the most important techniques in creating this environment is intimate contact between faculty and student as exemplified in small group teaching. The teacher should develop in the student the ability to think, not just memorize facts. Some question was raised on the full utilization of brilliant teachers in small groups with the inevitable result that others do not or cannot benefit from his brilliance.

The courses in psychiatry can not only give the student knowledge, but also can be taught in such a way that the student becomes aware of personal problems—his own and others. It was emphasized that help to the student in his personal problems must be completely separated from the administration of the school. The student must know that there is a sharp delineation of these problems from grade, discipline and other items associated with the dean's office.

There was a consensus that the examination should be a part of the educational enterprise and not just an instrument of the devil to torture him and come up with a grade. An examination may be a teaching instrument.

Examinations may and should serve many different purposes. They may indicate when the educational process is completed. They may be used to improve teaching. They may be useful in helping the student if careful evaluation and analysis of the examination show deficiencies

in certain mental processes or skills. They may give information on how much progress has been made between two time points. For example, an examination might be given on the first day of a course to serve as the base point.

The preparation of any one of the different means of appraisal is a joint enterprise between content and design or between substance and form. To develop an adequate examination the objectives of the entire educational goal and of the particular fragment under consideration must be defined. In an examination, material may be used beyond that required to arrive at a grade.

The idea was expressed by some that examinations might be abolished or at least made voluntary. Thus, examinations become a means for the student to test his progress, not for the faculty to assess his knowledge.

The relation of schools to state board examinations was discussed by several participants. The consensus seemed to be that they are a part of our society and that schools must bear them in mind, but that fear of them should be dispelled by the faculty and by pointing to the good record of previous graduates.

The discussions in this panel may be summarized as follows:

1. Medical schools should be conducted in an atmosphere which will lead to the maturation, emotionally and educationally, of the individual.

2. There are many different means to appraise progress in the maturation.

3. One of the most satisfactory means comes from an intimate relation of student and faculty in small group teaching.

4. Examination should be a part of the educational process and, therefore, teach as well as appraise.

Resolutions

Four resolutions were presented on Wednesday, October 31:

1. The following resolution was presented by Dr. Ward Darley and was unanimously passed:

WHEREAS Dr. Arthur C. Bachmeyer is a medical educator and administrator of national and international note, and

WHEREAS he has served the Association of American Medical Colleges ably and devotedly since 1925—notably as a member of the Executive Council in 1932-33, treasurer from 1935 to 49, president-elect in 1949-50, president 1950-51, and throughout this period as a valuable member of innumerable committees and as a representative of the Association at countless conferences and meetings,

HEREIN BE IT RESOLVED that the Association of American Medical Colleges in assembly at French Lick, Indiana, this 31st day of October, 1951, directs that an expression of deep appreciation be entered on the records of its transactions.

2. The following resolution was presented by Dr. Hugh Wood and passed by a vote of 30 to 18:

The concern of many of the deans and faculties of medical schools having relationship with Veterans Administration hospitals, over certain aspects of the operation of those hospitals, has been expressed in the discussions of various committees and groups of this meeting.

Medical care for the veterans is unsurpassed; we must keep it that way. The present high quality of this medical care is the result of the cooperation of the respective dean's committees and the faculties of the medical schools. First, the hospitals have been so well staffed that the professional work has been exceptionally high quality. Second, the resident training program in these hospitals has been so good that increasing numbers of competent young doctors have wished for postgraduate training in these institutions.

We believe that this combination of expert professional care and high-type residency training has made the service of the VA hospitals so desirable and so popular that increasing numbers of veterans have wished to be cared for in them. We know, of course, dean's committees and their faculties feel strongly that the very best of medical care should be preserved for veterans in accordance with the laws that have been enacted by Congress. On the other hand, we also believe that the use of VA facilities for veterans with non-service-connected illnesses and disabilities who are, by any reasonable definition, able to pay for adequate medical care should not be permitted. The use of veteran facilities in such manner we believe to be great at the present time, and growing. As a consequence of this it will become overwhelming and will threaten to destroy the high quality of medical care that dean's committees and their faculties have made possible for veterans.

This Association calls this matter to the attention of the various dean's committees with the suggestion that they give their earnest consideration to this threat to the continued provision of high quality medical care and the related educational pro-

gram. This Association recommends to the dean's committees and their faculties that they make an investigation of this situation and take appropriate action designed to correct it, thus insuring for needy veterans the best possible care. They deserve no less.

3. The following resolution was presented by Dr. Stockton Kimball and unanimously passed:

Be it resolved that the Association of American Medical Colleges, in cooperation with the American Medical Association Council on Medical Education and the federal services, study methods for implementing the previously approved curricular recommendations of the Joint Committee on Medical Education in Time of National Emergency.

4. The following resolution was unanimously passed:

The Association of American Medical Colleges wishes to express its appreciation for the fine hospitality provided it by the French Lick Springs Hotel and its staff at its 62nd Annual Meeting, October 29 to 31, 1951.

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1961-1962

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